Transgender Experiences: Exploring Identity Transition and Therapists' Attitudes

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List of Abbreviations

FTM	Female to Male
IPA	Interpretative Phenomenological Analysis
LGBT	Lesbian, Gay, Bisexual, Transgender
MHP	Mental Health Professional
MTF	Male to Female
NHS	National Health Service
SO	Sexual Orientation
TG	Transgender
TGNC	Transgender Non-conforming
UK	United Kingdom
USA	United States of America
WPATH	World Professional Association for Transgender Health

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Firstly, I would like to express my gratitude to the participants that made this research possible. Thank you for sharing your personal experiences and allowing me to walk with you a little of the way while you reflected on your journey. Following our time together, this quote felt particularly meaningful and apt:

"To be yourself in a world that is constantly trying to make you something else is the greatest accomplishment." - Ralph Waldo Emerson.

For advice in the initial stages, I would like to thank Ronete Cohen for the time you provided in phone conversations and generation of ideas. Much appreciation to my research team, Ms. Jo Kucharska and Dr. Magdalena Marczak for your guidance, support and dedicated hours supervising this research.

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Declaration

This thesis is an original piece of my own work and has not been submitted for any other degree or to any other institution. Emergent findings from the empirical paper were submitted as a poster presentation at the University of Warwick Postgraduate Research conference. The thesis was carried out under the academic and clinical supervision of Ms. Jo Kucharska (Clinical Director in Clinical Psychology, Coventry University) and Dr Magdalena Marczak (Lecturer in Clinical Psychology). Apart from the collaborations stated, all the material presented in this thesis is my own work. The literature review and empirical paper are written for submission to the International Journal of Transgenderism.

Summary

Gender identity is a burgeoning topic as people increasingly present to the National Health Service for assistance with gender incongruence concerns. The fluidity of gender and unique transition experience warrant further exploration given increased visibility of this topic. Also, with growing prevalence rates of people identifying as transgender, it is paramount the attitudinal responses of health care providers are investigated, given their crucial role in forging therapeutic relationships. This thesis informs understanding of transition experiences and current knowledge of mental health practitioners' attitudes towards the transgender population.

Chapter one is a critical systematic review of quantitative and mixed methodology research exploring mental health professionals' attitudes towards transgender people. Database and manual searches revealed thirteen studies appropriate for inclusion. Mental health professionals report overall positive attitudes; however, demographic variables were found to influence attitudes. The review highlights inadequate scales that conflate sub-populations of transgender people and were often adapted from scales measuring attitudes towards sexual orientation. Areas for future research are discussed.

Chapter two is a qualitative research study that explored the lived experience of transition with six Male to Female transgender participants. Using interpretative phenomenological analysis emergent findings relate to transition heterogeneity, intersectional forms of discrimination, and, authentic identity expression post-transition. Clinical and service implications are discussed alongside areas of future research.

Chapter three is a reflective account applying relevant theories of intersectionality to the researcher's self, research process and experiences while on the doctorate. It explores the parallels between the research area and facets influencing identity transition before embarking on professional qualification.

Overall word count: 20,007

Chapter 1: Literature Review

Mental health practitioners' attitudes towards people of transgender experience: A systematic review of the literature

Written in preparation for submission to the *International Journal of Transgenderism* (See Appendix A for author guidelines).

Overall chapter word count (excluding tables, figures, footnotes and references):7979

1.0 Abstract

A systematic review was conducted to critically evaluate and synthesize literature investigating mental health practitioners' attitudes towards transgender people.

Objective: Five primary objectives were outlined; first, elucidate factors that determine positive or negative attitudes. Second, establish whether overall attitudes are positive or negative. Third, explore whether training, education or experience influences attitudes. Fourth, investigate practitioner group differences. Fifth, examine participant demographics in relation to attitude trends.

Data Sources: A systematic electronic search was carried out in March 2017 using Medline, PsycINFO, PsycArticles, CINAHL, ASSIA, and Web of Science electronic databases. Manual citation and ancestral searches were conducted on identified papers.

Study selection: Qualitative, quantitative and mixed method studies were eligible for inclusion. A total of 13 papers of mixed quality were identified.

Results: Existing literature is limited to cross-sectional, quantitative data and fails to investigate differences between implicit and explicit attitudes. Small to moderate convenience samples reduce the generalisability of data. Overall attitudes were positive although negative attitudes were more frequent in male, Caucasian, heterosexual, religious, conservative mental health professionals.

Conclusions: Refined scales are needed to address the unique heterogeneity within transgender populations. Future research should focus on how attitudes impact care provided and employ longitudinal designs to explore the sustainability of targeted attitudinal training.

Keywords: *Transgender, Mental Health Professional, Attitudes, Review*

1.1 Introduction

1.1.1 Transgender context

Transgender is an umbrella term for those who do not identify with their natally assigned sex and instead, express, behave or identify as a gender not associated with their anatomy (National Center for Transgender Equality, 2014). Prevalence rates are dated; however, estimates range between 300,000 and 600,000 people who identify as transgender within the United Kingdom (UK; Reed, Rhodes, Schofield & Wylie, 2009). A large proportion seeks healthcare assistance to address gender incongruence concerns (NHS England, 2013).

1.1.2 Transgender healthcare

Transgender people face physical and mental health inequalities in comparison to their Cisgender, heteronormative peers (White-Hughto, Reisner & Pachankis, 2015). Guidance issued by the World Professional Association for Transgender Health (WPATH; Coleman *et al.,* 2011) promotes inclusive, and Trans-specific informed care. Nevertheless, evidence to date suggests this is lacking in several key areas, including a lack of tailored, individualised services from culturally-sensitive Trans-aware health professionals. Additionally, transgender people are concerned about real or perceived stigma, transphobia[1] and heterosexist[2] attitudes perpetrated by professionals (Benson 2013; Coleman *et al*., 2011; Nemoto,

[1] "Intense dislike of or prejudice against transsexual or transgender people." (OED Online, 2013).
[2] A societal ideological system that oppresses, denigrates, and stigmatizes any non-heterosexual form of identity, behaviour, relationship, or community (Herek, 1990).

Operario, Keatley, Nguyen & Sugano, 2005; Oggins & Eichenbaum, 2002; Winters, 2005).

Shipherd, Green and Abromovitz (2010) report an increase in mental health needs and presentation to mental health services for transgender people. In their survey of 130 transgender people, 68 people verified a need for mental health services but failed to seek help within the last year. A frequently cited barrier was knowing someone who had received inadequate treatment (n = 18), closely followed by stigma concerns. While this study did not elucidate the cause of the poor treatment, the authors do suggest this may be reflective of "provider insensitivity" (p. 103).

1.1.3 Attitudes of health care professionals

Attitudes are conceptualised as an integrated and complex system involving affect, cognition, and behaviour (Forsyth, 1994). These inter-related components can exert influence on one another to affect the attitude structure. Theorists describe the existence of two independent attitude components: implicit attitudes derived from “affective automatic reactions” when an object is encountered, and explicit attitudes: a “conscious evaluation” of an object (Echabe, 2013, p. 232). Although cognitive and explicit components may suggest one attitude, implicit and latent affective components may reveal contradictory attitudes.

A survey by Grant *et al.* (2011) report prejudiced and stereotyped attitudes towards transgender people has reached epidemic proportions. Transgender

people describe facing discrimination across a variety of domains including employment, schooling, accommodation, and healthcare. Of their sample, 28% reported postponing medical care due to discrimination and 19% reported being refused treatment due to their transgender or gender non-conforming status.

Gradually, as transgender issues have become more visible, research has assimilated attitudes held by healthcare professionals which may negatively impact on transgender people's ability to seek help. For instance, Nisley (2011) reviewed counsellor's attitudes specifically towards transgender people; participants held favourable attitudes in comparison to the general population, with gender being significant; females hold more positive attitudes than males. However, factors such as personal familiarity, training, experience and multicultural competency were deemed more predictive of positive attitudes, in line with previous findings (Hill & Willoughby, 2005).

In contrast, Dorsen (2012) synthesised a plethora of studies on nurses' attitudes towards the Lesbian, Gay, Bisexual and Transgender (LGBT) community. Despite a paucity of methodologically rigorous studies, all data demonstrated evidence of negative attitudes towards this population. Although such research contributes to the deconstruction of health care disparity, the topic remains complex and multifactorial. A criticism of the current literature is the conflation of the LGBT community as a unified group. The intersects of gender identity, or sexual orientation can evoke different discriminatory attitudes, and thus it may be difficult to separate and generalise attitudes to subpopulations (Worthen, 2013).

1.1.4 Rationale for current review

The complex health needs of the transgender population and client perspectives of care are well documented (Dispenza, Varney & Golubovic, 2017; Page, Burgess, Davies-Abbott, Roberts & Molderson, 2016). To the researcher's knowledge, no systematic review of mental health professional's (MHP) attitudes towards transgender clients exist. An indication for a separate investigation into potential prejudices, stigma, and discrimination towards transgender populations is warranted, rather than conflated data within the wider LGB community (Dean *et al.*, 2000; Solarz, 1999; Worthen, 2013).

1.1.5 Aims

The purpose of this systematic review is to critically evaluate existing empirical literature of MHP attitudes towards clients of transgender experience. Attention is given to:

- What constitutes a positive or negative attitude?
- What are the overall attitudes towards transgender people?
- Whether experience, training or education affect attitude?
- Whether any difference exists between practitioner group and attitude?
- Demographics that affect attitude trends.

1.2 Methodology

1.2.1 Searches

1.2.1.1 Database search

Following ethical approval from Coventry University (see Appendix B) an electronic literature search was conducted in March 2017 using the following

databases: PsycINFO, PsycArticles, Medline, Cumulative Index of Nursing and Allied Health Literature (CINAHL), Applied Social Science Index and Abstracts (ASSIA) and Science Direct. Time constraints were added (2010 onwards) to retrieve the most recent research conducted in line with changing attitudes towards transgender populations (Institute of Medicine (IOM), 2011). Keywords, MeSH terms, truncations and Boolean operators focused on three subject areas (Table 1.1).

Table 1.1 Search terms used for systematic review

Attitudes:	"mental illness" OR "psychotherapist attitudes" OR "stereotyped attitudes" OR "health personnel attitudes" OR "health attitudes" OR "attitudes" OR "psychologist attitudes" OR "implicit attitudes" OR "therapist attitudes" OR "sex role attitudes" OR "explicit attitudes" OR "counsel* attitudes" OR "sexual attitudes" OR "employee attitudes" OR "adult attitudes" OR "employer attitudes" OR "cognitive attitudes" OR beliefs AND
Transgender population:	transgender OR "transgendered persons" OR "gender fluid" OR "gender dysphoria" OR "gender identity disorder" OR "TGNC" OR "transgender non-conforming" AND
Mental Health Professionals:	psychologist OR psychotherapist OR "mental health services" OR "mental health professionals" OR nurse OR "approved mental health professional" OR counsel* OR "school psychologist" OR "school couns*" OR psychiatrist OR "social worker" OR "approved mental health professional" OR "approved social worker" OR training

1.2.1.2 Manual search

Ancestral searches of the selected articles for the systematic review were conducted by searching the reference list and citations. Figure 1.1 shows the procedure used for selecting articles following PRISMA guidance (Moher, Liberati, Tetzlaff & Altman, 2009).

1.2.2 Search results

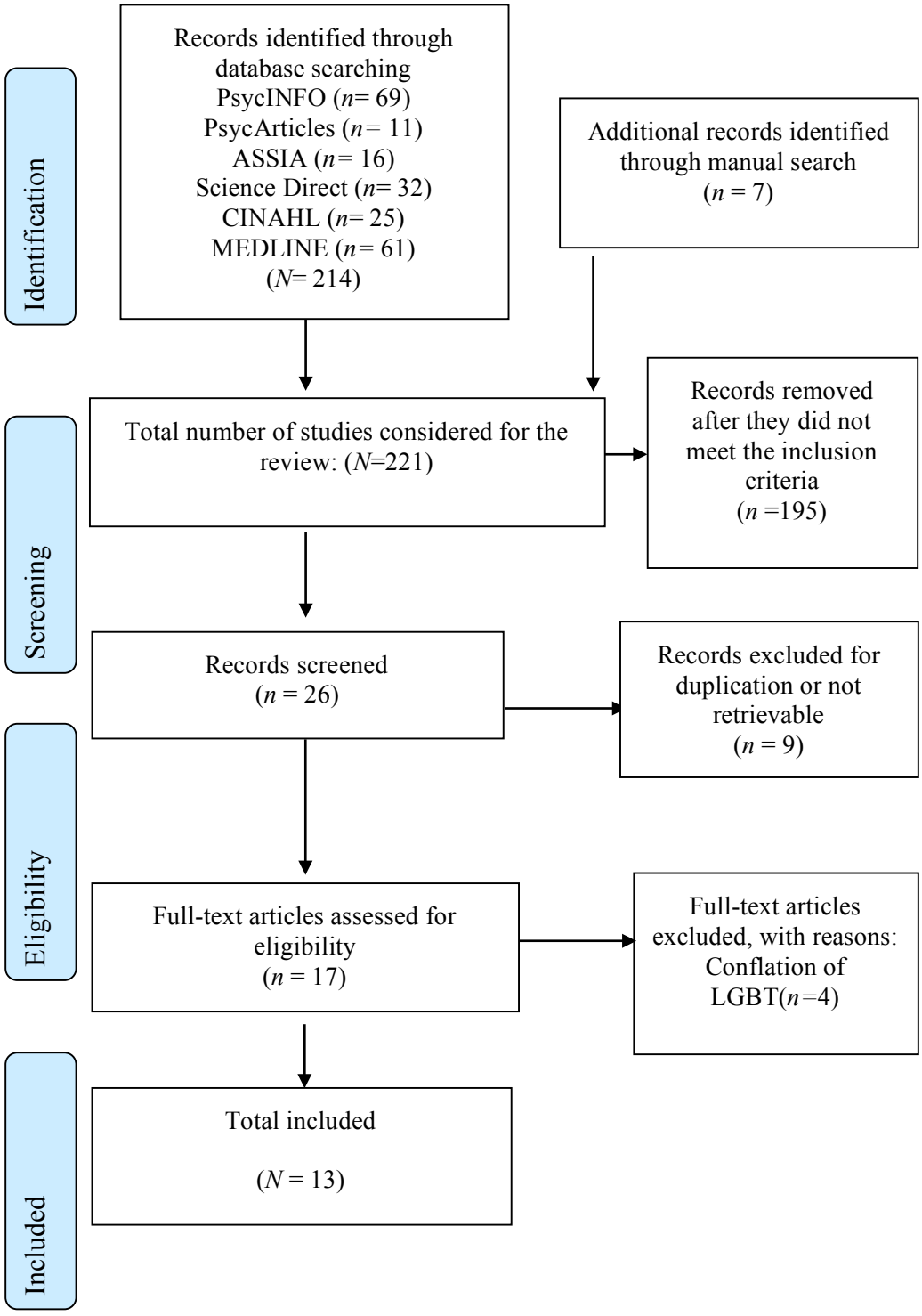

Figure 1.1 PRISMA flow diagram of study selection procedure

1.2.3 Selection criteria

Inclusion and exclusion criteria are defined in Table 1.2.

Table 1.2 Inclusion and exclusion criteria

Inclusion criteria:	• Target group: Mental health professional entitled to work therapeutically (psychological focus). • Quantitative, qualitative or mixed method primary research. • Studies where at least one of the primary aims is to ascertain mental health professionals' attitudes towards transgender people. • Dated 2010 to present day. • Peer reviewed research. • Studies written in English.
Exclusion criteria:	• Studies primarily focusing on non-mental health professional's attitudes. • Research exploring client perceptions of attitudes towards transgender care. • Unpublished manuscripts, abstracts and grey literature (doctoral thesis). • Data that does not clearly distinguish transgender clients from other LGBT populations within the results.

1.2.4 Quality Assessment Framework

In attempts to close the gap between research and practice, mixed-method systematic reviews are utilized to integrate and interpret high-quality research. To ensure this is conducted in a robust and reliable way and to avoid bias in data selection, measures of quality can be introduced to critically appraise the studies' validity (Harden & Thomas, 2010). Although Mays and Pope (2000) contest whether qualitative and quantitative research methods are eligible for assessment by the same quality criteria, given that relativist views would argue all research is valid within its own right.

The Quality Assessment Framework (QAF; Caldwell, Henshaw & Taylor, 2011) was chosen to assess credibility, transferability, dependability, and areas of bias, see Appendix C. The QAF is an efficient tool providing screening for both qualitative and quantitative literature. The Quality Assessment Framework is a 25-item checklist with a fully met criterion scoring 2; a partially met criterion scoring 1 and where the criterion is not met, this scores 0. Based on the rating scales, a quality score between 0 and 36 was calculated for each quantitative paper, and 0-50 for mixed method papers, with high scores indicating better quality. Scores were converted into percentages.

While no papers were excluded using this process, the quality assessment enabled a methodologically rigorous comparison and synthesis of convergent and divergent findings. Mays and Pope (2000) emphasise that each subsection may hold different importance and accordingly provision of the quality assessment

enables transparency over how quality was obtained. The Quality Assessment framework for all 13 papers can be found in Appendix D.

1.2.4.1 Results of Quality Appraisal

Following a systematic review of the literature, 13 studies were deemed acceptable for inclusion. Studies were of a mixed quality with assessments ranging from 39% - 89%. Interrater reliability was conducted with another researcher independently coding five randomly selected papers (see Appendix E). Discrepant findings were discussed with the researcher and often centred on unfamiliarity with the topic literature. The Kappa reliability coefficient for each paper is in Table 1.3. No coefficient score was below .75 with an overall coefficient reliability value of .88, which according to Altman (1999) represents a consistently strong pattern of inter-rater reliability.

1.3 Results

An overview of the 13 studies included in this systematic review is provided in Table 1.3.

See footnote for key of acronyms. *** Indicates author failing to report complete statistical data**

Table 1.3 Characteristics of reviewed studies

Author, date, country of origin and quality rating (QR)	Sample size, strategy and data collection method	Aims and areas covered	Data collection tools and data analysis	Participant details: (gender, age, ethnicity, sexual orientation, professional context)	Summary of key findings
Agee-Aguayo, J., Bloomqvist, E., Savage, T.A., and Woitaszewski, S.A. (2016) USA QR= 69% Inter-rater reliability score 1.00	91school psychologists completed surveys. Purposive sampling.	Aims: Assess school psychologists' attitudes toward TG students. Areas: (1) preparedness to support TG needs, (2) efforts to support implementation of AB1266 legislation, (3) demographic variables, (4) Whether training correlates with attitude to work with TG and schools' level of preparedness.	ATTSS amended version, Internal consistency α= .68. Preparedness Survey, Demographics Questionnaire. ANOVA. Cross-sectional.	Female (n = 72), Male (n = 18), 1 person's gender not reported. Aged between 27-71 years old, no mean provided. 1-40 years of professional experience. European-American/White (n = 64), Latino/a American (n = 14), African American/Black/African (n = 3), Asian/Pacific American (n = 2), "Other" (n = 7). Heterosexual (n = 66), "Homosexual" (n = 8), neither orientation (n = 17).	Positive leaning attitudinal scores. Influences on positive attitudes include individual preparedness to work with TG students (r = .60, p < .01). Negative correlations included assessment of school's preparedness and psychologist's attitudes (r = -.26, p < .05), individual preparedness and school's preparedness (r = -.30, p < .01), age and school's preparedness to address TG issues (r = -.22, p < .05), age and involvement in AB1266 planning (r = -.23, p < .05). No impact of ethnicity on attitudes, attitude and involvement of implementation of AB1266 (p > .05).
Ali, N., Fleisher, W., and Erickson, J. (2015). Canada QR = 81%	74 psychiatrists completed surveys. Purposive sampling using Survey Monkey.	Aims: Assess psychiatrists' and psychiatry residents' attitudes towards TG individuals. Areas: religiosity, psychiatric practice, political	GTS. Descriptive statistics. Cross-sectional.	Faculty members (n = 47), Residents (n = 27) General psychiatry (n = 27), Child and Adolescent psychiatry (n = 13), Geriatric psychiatry (n = 3), Addiction psychiatry (n = 2), Forensic psychiatry (n = 1), Retired (n = 1).	Overall GTS score (M= 58.6) lower than norm sample (M= 100.4). Females show more positive attitude (M= 55.7, SD= 15.8) than males (M= 60.8, SD= 17.2). Negative attitudes include religiosity (n = 5, M = 68.0, SD = 17.7), conservative political ideology

Inter-rater reliability score 1.00		ideology, and personal contact.		Married or cohabiting (n = 53), single (n = 17), Widowed/divorced (n = 4). Aged between 30-39 (n = 41.9%). Age range from 20-79 years. Female (n = 31), Male (n = 42), One participant did not answer. Ethnicity not reported.	(n = 3, M= 92.7, SD = 13.2) and no personal contact with TG people (n = 61, M= 59.4, SD = 17.2).
Bowers, S., Lewandowski, J., Savage, T.A., and Woitaszewski, S.A. (2015). USA QR= 78% Inter-rater reliability score .783	246 school psychologists. Convenience sample and snowball technique. Online survey.	Aims: Assess school psychologists' attitudes towards TG students. Areas: Overall attitudes, demographic variables, contact (never; sometimes; often), confidence (addressing emotional, educational and social needs of TG students), willingness (to address TG issues), and education needs.	ATTSS; Amended from the ATLGMS, Cronbach's alpha (α = .61). Demographic questionnaire, ANOVA, t tests. Cross-sectional.	Female (n = 204), Male (n = 37), No response (n = 5). European (n = 211), African American (n = 5), Hispanic American (n = 2), Latin (n = 4), Chican (n = 1), Multiracial (n = 6), Other (n = 10), No response (n = 7). Heterosexual (n = 183), "Homosexual" (n =15), Other (n = 46), No response (n = 2). Region: Northeast (n = 43), Southeast (n = 61), Central (n = 82), West (n = 2). Residence: Urban (n = 55), Suburban (n = 124), Rural (n = 66).	Overall high positive attitudes reported (M = 46.16, SD = 4.57). Ethnicity, work location, age, and degree level were all non-significant. Positive attitudes significantly associated with contact (F = 7.558, p = .001),* confidence (F = 14.576, p = .000),* willingness (F = 39.143, p = .000),* training (t = -2.468, F = 6.090, p = .014),* female gender (t = -2.376, p = .018),* and region (p = .001).*
Dispenza, F., and O'Hara, C. (2016). USA QR= 89%	113 psychologists and MHP. Self-selecting opportunity sample.	Aims: Measure correlates of counselling competency (knowledge, counselling skills, and affirming attitudes). Areas: Racial/ethnic minority identity, sexual minority	GICCS; internal consistency α=.83. SDS-17. Point bi-serial correlation. Hierarchical Regression Analyses. Cross-sectional.	78% Cisgender Female, 22% Cisgender Male. 49.5% Doctoral level, 50.5% Masters level. 69.7% early career professionals (<8 years), 30.3% advanced career professionals (>8 years). 47.8% White/European American, 31% Black/African, 5.3%	Knowledge accounted for a medium Cohen's effect (d = 29.4). Sexual minority identity (β = .18, p = .04), and being an advanced career professional (β = .25, p = .02) were significant predictors. Skills accounted for a small Cohen's effect (d = 14.5). Sexual minority (β = .20, p = .04) and advanced career professional

		identity, advanced training, and clinical experience.		Asian/American, 8% Latino/Hispanic, 8% Biracial/multiracial. 75% Heterosexual, 5.3% gay men, 5.3% Lesbian female, 12.4% Bisexual, 2% Queer. 17.7% aged 18-27, 50% aged 28-37, 17.7% aged 38-47, 10.6% aged 48-57, 4% aged >58.	(β = .27, p = .02) were significant predictors. Attitude accounted for small Cohen's effect size (d = 14.9). Sexual minority (β = .28, p = .005) was a significant predictor. After controlling for age, gender, and social desirability (all non-significant) identifying as a racial/ethnic minority (β = .19, p = .04), identifying as a sexual minority (β = .28, p = .002), and being an advanced career professional (β = .30, p = .006) significantly contributed to counselling competency. Educational level was not significant in the model (β =.05, p = .63).
Johnson, L., and Federman, E.J. (2014). USA QR=86%	384 Veteran Health Administration Clinical Psychologists. Purposive sampling via self-report, using Survey Monkey.	Aims: Assess experience and attitudes of LGBT issues. Areas: Demographic, attitudes, training, experience, current practices, self-reported competence, age and region.	Adapted survey Chi square, t-test. Cross-sectional.	Sample split into older; born < 1969 (n = 209) and younger; born > 1969 (n = 168). 65.4% Female, 34.3% Male, .3% Transgender Male. Mean age 45.3 years (SD = 10.9). Ethnicity not asked. Sexual identity not asked. Doctorate completed a mean of 12.1 years ago (SD = 9.4).	Younger psychologists had more LGBT affirmative attitudes: t (363) = 2.179, p < .05. Region: progressive state more positive attitudes than conservative state: t (155) = 2.43, p < .05. Higher graduate training significantly predicted postgraduate career training in comparison to lower graduate training, TG: t = (365) = 2.72, p <. 01 and affirmative attitude scores: t (363) = 2.73, p < .01. Training on Diversity Generally (DG) and Sexual Orientation (SO) significantly more likely than TG training: p < 0.01.

Kanamori Y., and Cornelius-White, J.H.D. (2017). USA. QR=81% Inter-rater reliability score .753	95 counsellors and counsellors in training. Convenience and purposive sampling.	Aims: Assess counsellors (C) and counsellors in training (CIT) attitudes towards TG. Areas: Demographic variables compared against dimensions of Interpersonal Comfort (IC), Sex/Gender Beliefs (S/GB) and Human Values (HV).	TABS; internal consistency (α= .98) MCKAS; reliability (α = .85). Online survey: MTurk Cross-sectional	Female (*n* = 57), Male (*n* = 38). Heterosexual (*n* = 82), Bisexual (*n* = 5), Gay or Lesbian (*n* = 5), Queer (*n* = 2), Other (*n* = 1). African American (*n* = 6), Asian/Pacific Islander (*n* =1), White (*n* = 77), Latino/ Hispanic (*n* = 8), Native American (*n* = 1), Biracial/multiracial (*n* = 2).	Overall high attitude scores reported (*M* = 5.71, *SD* =1.04); Females scored higher on all TABS subscales: IC: *t* (93) -2.16, *p* = .034; S/GB: *t* (93) = -2.24, *p* = .027; HV: *t* (58) = -2.60, *p* = .012. Heterosexual participants scored lower on all TABS subscales: IC: *t* (41) = - 4.95, *p* < .001; S/GB: *t* (93) = -2.59, *p* = .011; HV: *t* (78) = -3.89, *p* < .001. No significant difference for age or stage of training. Significant correlation between personal familiarity and IC: *r* = 0.25, N = 95, p < .05, and personal familiarity and S/GB: *r* = 0.31, *N* = 95, *p* < .01. Significant negative correlation between professional experience and IC: *r* = -0.33, *N* = 95, *p* < .01, and professional experience: *r* = -0.489, *N* = 95, *p* < .01. CIT professional contact was negatively correlated with TABS total: *r* = -0.547, *n* =38, *p* < .01. Specialized training in TG issues was negatively correlated with HV: *r* = -0.231, *N* = 95, *p* < .05. MCKAS positively correlated with TABS moderate to large relationships: *r = .288, n* = 57, *p* <. 01 to *r = .654, n = 38, p* < .01).

Kidd, J.D., Bockting, W., Cabaniss, D.L., and Blumenshine, P. (2016). USA QR =56%	22 PGY2 and PGY3 psychiatry residents. Survey. Purposive sampling.	Aims: To assess intervention of TG training. Areas: Perceived empathy, knowledge, comfort, motivation and interviewing skill.	Self-created survey Fischer's exact tests for categorical variables and *t* tests. Experimental design	No data given	Post training survey revealed significant increases in empathy (36 vs 73 %, p = .03)*, knowledge (5 vs 55 %, p = .0006)*, comfort (36 vs 73 %, p = .03)*, motivation for future learning (36 vs 73 %, p = .03)* No changes in interview skill. 90 day follow up not statistically significant different from baseline.
O'Hara, C., Dispenza, F., Brack, G., and Blood, R.A. (2013). USA QR= 63%	Mixed method study. Counsellors in training. Phase one: (N = 87) Phase two (N = 7) Opportunity sample.	Phase one aims: Investigate differences in counselling competencies. Areas: Program (beginning or advanced) and practicum (in practicum or not) and contact with TG people (personal contact versus none). Phase 2 aims: Explore how counsellors in training constructed their educative experiences around TG identities. Areas: Structured questionnaire.	Phase one: Demographic questionnaire, GICCS adapted from the SOCCS; overall Cronbach's alpha (α= 0.87). Chi-square, Non-parametric ANCOVA. Cross-sectional. Phase two: Qualitative, focus interviews. Open and Axial coding mentioned indicating the use of Grounded Theory.	Phase one: Female (n = 74), Male (n = 10); FTM TG (n = 3). White/European American (n=62), African American/Black (n=14), Biracial (n = 3), Latino/a American (n = 5), "Other" race/ethnicity (n = 3). Aged 18-62 92% sample Heterosexual ¼ of sample did not know anyone who was TG. Phase two: (N = 7) 6 Females; 1 Male. Average age was 29 (SD = 3.63) Experience: doctoral student in education (n = 1), rehabilitation counsellor in training (n = 1), mental health counsellor in training (n = 5). Black/African American (n = 2), White/ European American (n = 4), Black/Asian American (n = 1).	GICCS full scale used as final indicator of TG counselling competency: awareness: r= .685, N = 87, p < .001; skills: r=.571, N = 87, p < .001; and knowledge: r= .669, N = 87, p < .001. Non-significant findings on demographic data: Gender: χ^2 (2) = 2.472, p =-290; Race/Ethnicity: χ^2 (4) = 4.349, p= .364; Ability status: χ^2 (1) = .319, p = .572; Sexual orientation: χ^2 (3) = 1.502, p = 0.682. One way ANCOVA with number of courses as a covariate, alpha adjusted to .01. Main effect for personal contact with someone who was TG: F (1, 75) = 20.85, p < .001, hp^2 = .218. Phase 2: Five themes; (1) Terminology, (2) Sources of information and knowledge, (3) Approaches to working with TG people, (4) Counsellor in training characteristics, (5) Recommendations.

Riggs, D.W., and Bartholomaeus, C. (2015). Australia QR=53% Inter-rater reliability score .746	16 qualified counsellors and 12 psychologists. Online survey. Snowball sample.	Aims: Scoping review of school counsellor and psychologists' capacity to support inclusion of TG students. Areas: Education, school counsellor attitudes and competencies in working with TG clients.	ATTIS CATTS CWCTM; no validity measure, reliability (α = .97). Multiple regression. Cross-sectional.	Female (n = 17), Male (n = 11). Average age 38.43 years old (SD = 12.23). 25% had taken specialist training to work with TG, 39.43% had previously worked with TG students. Cisgender and Heterosexual sample.	Overall moderate average acceptance score: (M= 43.10, SD = 2.11). Confidence score: (M= 27.90, SD = 2.27). Females reported higher accurate clinical knowledge (t = 3.09, p =.02)* and higher levels of acceptance (t = 3.27, p =.03, d = 2.42)* Prior experience was positively related to confidence in working with TG (t = 2.63, p = .03, d = 2.33)* Moderate negative correlation with degree of religiosity and acceptance (r = -.55, N = 60, p < .01). Strong positive correlation between acceptance and confidence (r = .59, N = 60, p < .01), accurate clinical knowledge and confidence (r = -.619, N = 60, p = <.01).
Riggs, D.W., and Bartholomaeus, C. (2016a). Australia QR= 58%	96 mental health nurses. Online Survey using Survey Monkey. Opportunistic sampling.	Aims: Examine the predictor of two variables: Knowledge and attitudes towards TG people. Areas: Experience and training in working with TG clients, attitudes towards TG people, clinical knowledge related to working with TG clients.	ATTIS amended, CATTS amended, Demographic questionnaire. ANOVA, Chi Square. Cross-sectional.	72% Female and 28% Male. Average age of sample 48.31 (SD= 11.22). Ethnicity not reported. Sexual orientation not reported. Practice setting included: medical context (42.7%), community mental health (36.5%), private practice (9.4%), child and family service (4.2%), education (4.2%) and correctional services (3.1%).	Overall average attitude was positive in the sample (32.11, SD = 4.69). Significant differences emerged between practice contexts and attitudes: F(6, 78) = 4.018, p = <.001. Child and family services statistically less likely to have worked with TG, have taken training, have lower positive attitudes and report lower clinical knowledge. Significant differences emerged between clinical knowledge and attitudes:

					$F(6, 93) – 10.44$, $p <.001$. Positive attitudes correlated to additional training in TG: $t = 2.904$, $p < .05$, d=1.17* Strong positive correlation between attitude and clinical knowledge: $r = .703$, $p < .001$. A moderate negative correlation between attitudes and religiosity: $r = .330$, $p < .05$. High overall level of clinical knowledge: Average score M= 41.11, SD = 9.02. Females reported higher levels of clinical knowledge than male's: $t = 3.049$, ($p <.05$), $d = 0.78$* Participants who had previously worked with TG clients reported higher levels of TG knowledge: $t = 3.2314$, ($p <.001$), $d = 0.94$* Strong positive correlation with increasing age and higher levels of clinical knowledge: $r = .455$, ($p < .001$).
Riggs, D.W., and Bartholomaeus, C. (2016b). Australia QR= 78%	304 MHP. Online Survey. Purposive sampling.	Aims: Assess demographic variables in relation to attitudes and knowledge in working with TG clients. Areas: Demographic variables and knowledge, attitudes and confidence.	CATTS, ATTIS, CWTCM, Demographics questionnaire. ANOVA. Cross–sectional.	Mental Health Nurses (31.6%), Psychologists (24%), Counsellors (20.4%), Social Workers (16.1%) and Psychiatrists (7.9%). 78.3% female Community Health (36.5%), Medical Practice (24.7%), Private practice (19.7%), Education (9.2%), Child and Family Services (5.6%) or Correctional services (4.3%).	Psychiatrists hold significantly less clinical knowledge than other professional groups: $F(4, 218) = 5.501$, $p < .001$. Training and previous work with TG clients indicated higher clinical knowledge: (M= 54.53, SD = 8.11) and (M= 53.23, SD = 7.89) respectively. Females were more accurate in their clinical knowledge than male's: t (*) = 3.616, $p < .001$, $d = 0.86$.

					Counsellors report the highest levels of confidence: (M= 26.21, SD = 4.97) Religiosity was negatively correlated with comfort of interaction with TG: r = -.25, p < .01.
Riggs, D.W., and Sion, R. (2016) Australia QR = 39%	Study 1 N/A Study 2: 66 Psychologists. Online survey. Purposive Sampling. Study 3: 73 psychologists Online survey. Purposive Sampling.	Aims: Assess gender differences in Cisgender Psychologists' and trainees' attitudes towards TG people. Areas: Gender only.	Study 2: GTS-RA; no scale reliability or validity referenced. Factor analysis. Cross-sectional. Study 3: CATTS; α = .92. Cross-sectional.	Study 2: Female (n = 51), Male (n =15). Cisgender. Age not stated. White–Australian. Profession sub type not stated. Heterosexual. Study 3: Female (n = 51), Male (n = 22). Cisgender. Age not stated. White –Australian. Profession sub type not stated. Heterosexual.	Study 2: Factor analysis found Genderism/transphobia accounted for a third of the variance: (35.44%), α =.87. Females scored significantly more positively (M = 22.79, SD = 6.14) than males (M = 27.50, SD= 6.14), t (*) = 2.133, p = < .05, d = 0.67. Study 3: Men reported significantly less positive attitudes (M = 86.53, SD = 7.23) than women (M = 98.70, SD = 6.23), t (*) = 3.83, p < .05, d=1.80.
Willoughby, B.L.B., Hill, D.B., Gonzalez, C.A., Lacorazza, A., Macapagal, R.A., Barton, M.E., and Doty, N.D. (2010). USA. QR=58%	88 MHP and Trainees. Snowball and purposive sampling.	Aims: Investigate attitudes towards TG people. Areas: Genderism, transphobia and gender bashing.	GTS, Demographic questionnaire, KATI. Mann Whitney U test. Cross-sectional.	Females (77%), Males (22%). Mean age 32.3, SD = 10.1 Heterosexual (82%), Gay or Lesbian (10%), Bisexual (8%). Caucasian (81%), Latino (6%), Asian (2%), African-American (4%) non-identified (1%).	Overall favourable attitude scores (M = 57.8, SD = 21.0). Factual knowledge and GTS scores were negatively correlated: (r = -.27, p < .01). Sexuality and gender training was significantly associated with lower GTS scores: (z = -.84, p = .40).

Key for acronyms: Transgender (TG); Attitude Towards Transgender Student questionnaire (ATTS; Bowers, Lewandowski, Savage & Woitaszewski, 2015); Genderism Transphobia Scale (GTS; Hill & Willoughby, 2005); Attitude Towards Lesbians and Gay Men Scale (ATLGMS; Herek & McLemore, 2011); Gender Identity Counselor Competency Scale (GICCS; Dispenza & O'Hara, 2016); Sexual Orientation Counselor Competency Scale (SOCCS; Biddell, 2005); Social Desirability Scale-17 (SDS-17; Stöber, 2001); Transgender Attitudes and Beliefs Scale (TABS; Kanamori, Cornelius-White, Pegors, Daniel & Hulgus, 2016); Multicultural Counseling Knowledge and Awareness Scale (MCKAS; Ponterotto, Gretchen, Utsey, Rieger, & Austin, 2002); Attitude Towards Transgender Individual Scale (ATTIS; Walch, Ngmake, Francisco, Stitt & Shingler, 2012); Counselor Attitude Towards Transgender Scale (CATTS; Rehbein, 2012); Confidence in Working with Transgender Client Measure (CWTCM; Riggs & Barthomomaeus, 2015); Genderism and Transphobia Scale-Revised Australia (GTS- RA; Riggs & Sion, 2016); Knowledge About Transgender Individuals (KATI; Willoughby, Hill, Gonzalez, Lacorazza, Macapagal, Barton & Doty, 2010).

1.3.1 Findings of studies

1.3.1.1 Aim 1: Reported attitude constructs

Across 13 studies, there were 14 different scales used; Attitude Towards Transgender Student questionnaire (ATTS), Genderism Transphobia Scale (GTS), Attitude Towards Lesbians and Gay Men Scale (ATLGMS), Sexual Orientation Counselor Competency Scale (SOCCS), Social Desirability Scale-17 (SDS-17), Gender Identity Counselor Competency Scale (GICCS), Transgender Attitudes and Beliefs Scale (TABS), Multicultural Counseling Knowledge and Awareness Scale (MCKAS), Attitude Towards Transgender Individual Scale (ATTIS), Counselor Attitude Towards Transgender Scale (CATTS), Confidence in Working with Transgender Client Measure (CWTCM), Genderism and Transphobia Scale-Revised Australia (GTS-RA), Knowledge About Transgender Individuals (KATI), and Preparedness survey. Some measures were derived through factor analysis with attitudes assessed across affective, cognitive and behavioural components. In addition, some scales were adapted from measures focusing specifically on sexual orientation. Due to the diversity of scales employed, meta-analysis was not possible and comparability is limited

However, several studies do comment on the specific subscales in which construction of positive attitudes occurs. These included Interpersonal Comfort (IC), Human Values (HV), and Sex/Gender Beliefs (SGB) (Kanamori & Cornelius-White, 2017). Thus, participants who rated their interpersonal comfort with transgender people highly, held higher beliefs of transgender people's human value, and fluid views on gender, were likely to score more positively. Comfort to

work with or treat transgender people was frequently related to positive attitudes (Agee-Aguayo *et al.,* 2016; Riggs & Bartholomaeus, 2016a; Riggs & Bartholomaeus, 2016b). The relationship with comfort to treat or work with transgender people was often positively related to confidence or clinical knowledge (Agee-Aguayo *et al.,* 2016; Bowers *et al.,* 2015; Johnson & Federman, 2014; Riggs & Bartholomaeus, 2015; 2016b).

Moreover, participants who believe transgender people deserve equal rights, show a desire to learn more about transgender people, and a willingness to address transgender issues, score highly on holding positive attitudes (Bowers *et al.,* 2015). Participants who maintain an awareness of gender being non-binary and the impact of socialization on gender construction held more positive attitudes (O'Hara *et al.,* 2013). These findings could be suggestive of facets that exemplify transgender alliance: advocating and overtly offering support, with the literature on transgender alliance burgeoning (Ramsey, East & Evans, 2015).

In contrast, negative attitudes correlate with higher ratings on statements such as: 'Transgenderism is a sin', 'Transgenderism is immoral', 'Transgenderism endangers the institution of the family' (Riggs & Bartholomaeus, 2016a). These statements reflect ideologies found within religion and conservative attitudes, which correspond to findings discussed in Aim 5*: Demographics and attitude trends*.

Both Riggs and Sion (2016) and Willoughby *et al.* (2010) found that higher scores on the genderism[3]/transphobia subscales indicated more negative attitudes. Riggs and Sion (2016) also reported high scores on Gender bashing and Gender teasing reflected more negative attitudes.

1.3.1.2 Aim 2: Overall attitudes towards transgender population

Of the 13 studies reviewed, eight explicitly provided details regarding the overall attitudes towards transgender people (Agee- Aguayo *et al.,* 2016; Ali *et al.,* 2016; Bowers *et al.,* 2015; Riggs & Bartholomaeus, 2015; Riggs & Bartholomaeus, 2016a; Riggs & Bartholomaeus, 2016b; Kanamori & Cornelius-White, 2017; Willoughby *et al.,* 2010). The remaining five studies under review refer to specific associations discussed in later sections of the review. Given the variety of scales utilised, for ease of understanding, they will be grouped together here: Ali *et al.* (2016) and Willoughby *et al.* (2010) compared psychiatrists, and MHPs respectively on the GTS. Overall attitudes were positively leaning (M= 58.6, SD = *16* and M = 57.8, SD = 21 respectively) in comparison to norm values (M = 100.4). However, the GTS specifically addresses Male to Female (MTF) transgender persons so may only be assessing attitudes towards this sub-population.

Next, three studies utilised the ATTIS and CATTS, findings of which are limited based on factor analysis conducted to identify significant subsets of items from

[3] Genderism relates to a cultural concept that gender is binary and therefore only two genders exist, and it can also refer to the belief that one gender is superior, often male (Collins, 2002)

each scale, following non-significant findings in their complete form. Nonetheless, Riggs and Bartholomaeus (2015) reported positive acceptance scores in Cisgender school counsellors and psychologists ($M = 43.10$, $SD = 2.11$). Similarly, Riggs and Bartholomaeus (2016a) also found positive attitudes in mental health nurses ($M = 32.11$, $SD = 4.69$). The third study to use this measure (Riggs & Bartholomaeus, 2016b) failed to report the overall scores. However, reliance on factor analysis raises concerns regarding the validity of the scales used in these populations.

Furthermore, Bowers *et al*. (2015) and Agee- Aguayo *et al.* (2016) incorporated measurements specifically focusing on school setting: the ATTSS. Bowers *et al.* (2015) report a positive attitude from a moderate sample of school psychologists ($N = 246$, $M = 46.16$, $SD = 4.566$). In contrast, Agee-Aguayo *et al.* (2016) fail to provide descriptive data but comment on this being positively leaning in their sample of 91 school psychologists. Both studies report questionable internal consistency Cronbach alpha scores of .61 and .68 respectively. These factors contribute to the reduced quality assessment score, along with neither author incorporating a social desirability scale to control for biased self-report. The questionnaire, designed by Bowers *et al.* (2015) was originally piloted on a small sample of graduate students, thus may not be reflective of the wider population, nor the designated population under research. The authors acknowledge revision is needed, but highlight the dearth of appropriate scales for this specialized area.

Finally, Kanamori and Cornelius-White (2017) used the TABS; an environment nuanced three-factor scale assessing Interpersonal Comfort, Sex/Gender Beliefs, and Human Value. Their sample included 95 counsellors and counsellors in training recruited from a convenience and web-based approach. Positive attitudes were depicted across all three scales and are comparable to other healthcare groups. However, their attempts at reducing sampling bias may have introduced confounding variables; with 21 participants removed from the study during "data cleaning" because of possible "dishonesty or misrepresentation" (p.43), this casts wider doubt over the recruitment methodology. Reliability, internal consistency, and validity of the measures were commented on by the authors reflecting a strength of quantitative methodology, but not reported consistently.

In summary, therapists' attitudes towards transgender clients appear overall positive, although findings from studies report variables which impact upon this and the variance within the samples is discussed below.

1.3.1.3 Aim 3: Does education, training, or, experience affect attitudes?

To consider training's effect on therapists' attitudinal responses, the type of training and impact was synthesized. Johnson and Federman (2014) in their study of 384 Veterans Health Administration (VHA) clinical psychologists found training was significantly more likely to focus on diversity generally (DG) and sexual orientation (SO) than transgender training ($p < .001$). Despite a relatively modest sample, the response rate was only 17%. High refusal rates are associated with non-generalizability and response bias (Burns & Grove, 2009).

In addition, findings from Agee-Aguayo *et al*. (2016) show that minimal provision of transgender-specific training occurs in graduate courses (20%), normally within one diversity session, and furthermore, only 40% of participants had gone on to engage in additional training. The decision to use a new measure (Preparedness scale) with no reference to piloting this and reliance on estimated numerical values may introduce questionable reliability of the results.

Moreover, despite a high internal reliability for the GTS (α = .92), a study by Willoughby *et al.* (2010) was of low quality concerning data collection and sample recruited. This study found sexuality and gender training led to significantly lower levels of transphobia and genderism (z = -2.23, p = .03). Besides, cultural training was not significant in reducing transphobia, suggesting that training needs to be specific to be of value.

In the only study to evaluate pre, post and follow-up measures and assess the durability of training implemented, Kidd *et al.* (2016) designed a transgender specific training programme for a small sample of psychiatry residents (N = 22). While a control group could have improved the robustness of the design, findings indicated significantly improved ratings on empathy, knowledge, comfort and motivation for future learning, immediately post-intervention. No significant improvements were reported on interview skill suggesting different training is needed for this proficiency. Limited demographic data and purposive sampling make generalising findings difficult, and the 90-day follow-up data highlight the need to investigate the durability of training implemented. The authors report no

significant changes compared to baseline data, suggesting training may only be temporarily effective in influencing attitude. Also, it remains unknown whether the training effects lasted 90 days or reduced before this.

Next, seven studies focus on the impact of training on attitude; Riggs and Bartholomaeus (2015; 2016a; 2016b) discuss a reasonable to high clinical knowledge found within their samples and later report positive correlations between training and clinical knowledge. Furthermore, clinical knowledge and training are both positively correlated with attitudes; thus, participants with more clinical knowledge and training report more positive attitudes. There are concerns regarding results reported, specifically with Riggs and Bartholomaeus (2015) where standard deviations exceed range and positive correlations are reported with negative correlation outputs provided in the paper. Thus, caution is warranted in the interpretation of their data.

Additionally, findings from Johnson and Federman (2014) found clinicians with higher graduate training significantly predicted postgraduate career training, affirmative attitudes towards transgender people, and clinicians who were more likely to ask about sexual orientation, all at the $p < .01$ value. Similarly, Bowers *et al.* (2015) found transgender-specific training was significantly related to positive attitudes ($p = 0.14$).

In keeping with this, O'Hara *et al.* (2013) conducted a study with counsellors and counsellors in training regarding training influence on attitude. Here, bivariate

correlation revealed a medium-sized positive correlation between the GICCS full scale score (r =. 242, p = .03). This modified scale reported a range of low to high Cronbach alpha scores on the individual subscales, and without an additional measure of social desirability or reliability measures, findings should be interpreted with caution. The qualitative data did not elaborate further on this, and due to the nature of failing to identify participant quotes, one is unsure if themes are representative of all who participated.

These previous findings are in contrast with Kanamori and Cornelius-White (2017) who found no significant influences from multicultural counselling or sexuality/gender training. This divergence continues as the specialized training in transgender issues was negatively correlated with the combined group's attitudes, and counsellors' in training Human Value score. While findings regarding multicultural training echo Willoughby *et al.'s* (2010) results, the surprising outcome regarding human values and sexuality training are discrepant with earlier reported data.

Finally, three studies (Bowers *et al.,* 2015; Dispenza & O'Hara, 2016; Riggs & Bartholomaeus, 2016b) comment on education level not influencing MHP attitudes or competency respectively. Bowers *et al.* (2015) cite education as a skill and not an attitude; however, these findings are unexpected given higher education would allude to more exposure to training and skill acquisition. Also, Riggs and Bartholomaeus (2016b) found that education level was non-significant in addition to training in working with families of transgender clients.

Of note, Dispenza and O'Hara's (2016) survey reflects a high calibre of quality, reporting on the GICCS amongst a varied professional group (Masters level social workers, counsellors and applied psychologists). Indeed, the authors define how being an advanced career professional is a significant predictor on subscales of knowledge and skills in working with transgender people. However, a limitation of their study is a failure to enquire about the type of contact with transgender people.

One possible cause for the unexpected finding may be reflective of the participant's age group. Most participants were aged between 28-57 years old; historically there has been a lack of training on transgender issues. The invisibility of transgender awareness may have been more prominent during participant's educational experience. Thus, it may account for higher education being non-significant in these samples. However, this cannot be compared to Bowers *et al.* (2015), as age demographics are not reported but warrants further exploration.

1.3.1.4 Aim 4: Practitioner group associations and attitudes

This aim concerned whether professional type varied regarding attitudes reported and whether the type of contact influenced attitudes. Initially, Riggs and Bartholomaeus' (2016b) survey collated self-report measures on the attitudes of psychiatrists, mental health nurses, counsellors, social workers, and psychologists. While they found that the practice context was not a significant influential aspect of attitudes, psychiatrists and mental health nurses were more likely to have contact with transgender people than other groups. Of concern, their sample also

reported that psychiatrists and mental health nurses had lower levels of clinical knowledge to work with transgender people, highlighting that the professionals with the most contact felt the least clinically knowledgeable to manage transgender issues.

Specifically concerning psychiatrists' attitudes, Ali *et al.* (2015) found Child and Adolescent Mental Health psychiatrists within their sample held more positive attitudes than their general psychiatry colleagues. Also, there was a trend for staff to hold more positive attitudes on the GTS than residents. However, due to the small sample size, the study is underpowered, and reliability is questionable. Furthermore, due to sampling method employed, this may be reflective of the teaching practices within this University and not the wider profession.

However, additional findings from Riggs and Bartholomaeus (2016a) dispute that the child and adolescent context may hold more positive attitudes. Within their sample of 96 mental health nurses, participants working in the child and family context held more negative attitudes in comparison to the medical context, private practice, correctional services, educational setting, and community mental health team. However, additional factors may have influenced these findings such as less clinical knowledge and being statistically less likely to have worked with transgender people. Although quantitative data provides additional rigour and robustness, it lacks the richness of data found within qualitative research which may be able to elaborate on such findings.

Given the important association of contact, a substantial number of studies explored whether the type of contact professionals have influenced their attitudes. Three reviewed personal contact, (Ali *et al.,* 2015; Riggs & Bartholomaeus, 2015; Kanamori & Cornelius-White, 2017), seven reviewed professional contact (Ali *et al.,* 2015; Bowers *et al.,* 2015; Johnson & Federman, 2014; Riggs & Bartholomaeus, 2015; Kanamori & Cornelius-White, 2017; Riggs & Bartholomaeus, 2016a; Riggs & Bartholomaeus, 2016b) and one was unclear on contact type (O'Hara *et al.,*2013).

Evidence concerning professional contact suggests both knowledge and confidence working with transgender people increases with contact (Riggs & Bartholomaeus, 2015; Riggs & Bartholomaeus, 2016a; Riggs & Bartholomaeus 2016b). Furthermore, contact with at least one transgender person correlates with more positive attitudes than never having contact (Bowers *et al.,* 2015). Yet, findings from both Ali *et al.* (2015) and Kanamori and Cornelius-White (2017) suggest that positive attitudes decrease with more frequent professional contact, precisely on subscale measures of Comfort and Human Value. Thus, professionals who may frequently be working with transgender people may hold less positive attitudes. Ali *et al.* (2015) aver that these findings could be related to professional contact eliciting more overt reactions that would usually be suppressed through lack of interaction. Further research is required to investigate these findings given the gravity of their importance of those working closely with this population.

Johnson and Federman (2014) focus more on the demographic data, reporting that between 58%-75% of clinical psychologists did not see transgender clients through graduate school, post-graduate non-VA, and VA settings. Of concern, 92% of the participants within their sample did not enquire about gender identity on intake despite the American Psychological Association's (APA, 2011) emphasis on both gender identity and sexual orientation being important areas of cultural competence. A caveat of this survey is the timing of the study, occurring just prior to the repeal of *Don't Ask, Don't Tell* (2010); a revocation which allowed gay, lesbian and bisexual people to serve openly in the United States Armed Forces. This emphasises the need for a review of training and understanding of the competency necessary to work with transgender people, given this issue being less visible within this setting.

The earlier findings pose anomalies for intergroup theory[4] (Pettigrew & Troop, 2006). Thus, personal contact with transgender people may offer insights into whether this distinction makes a difference to attitudes. Both Ali *et al*. (2015) and Kanamori and Cornelius-White (2017) report that participants who hold personal contact with a transgender person report more positive attitudes, and specifically more fluid attitudes regarding gender and higher levels of comfort in interaction. The personal contact did not influence Human Values, although we note from earlier findings how specialized transgender training did (negatively correlated).

[4] A theory suggesting more favourable attitudes towards a group in which there is personal contact.

Despite O'Hara *et al.* (2013) not defining the type of contact, knowing someone who was transgender associated with significantly higher scores on the GICCS. As a mixed method study which employed qualitative focus groups, additional aspects were investigated. Here, a small sample (N = 7) of majority female counsellors (n = 6) were interviewed using a structured interview schedule. Although credibility and trustworthiness of data analysis were achieved through triangulation of data, the authors describe methodology from grounded theory but do not explicitly state this as the method of analysis.

Findings highlighted how counsellors experienced confusion regarding appropriate terminology to use. In addition, conflicting sources of information and knowledge from the media, known as parasocial contact (Schiappa, Gregg & Hewes, 2005) was cited as a difficulty. Personal contact and formal teaching left participants reflecting that transgenderism is a topic that is not given much focus. A key theme emerged focusing on participants' ability to connect to emic worldviews of transgender people, specifically marginalization, fear, and safety. This emotional connection fostered empathy and increased participants' awareness of gender flexibility. Additionally, the need to advocate for this client group emerged as a finding, which supports existing research on the importance of therapists being allies to the transgender community (Ramsey, East & Evans, 2015).

In summary, it appears that empathy towards transgender experiences, in conjunction with personal contact, is more conducive to developing positive

attitudes than professional contact. There may be latent variables related to professional contact that remain unknown, such as stress associated with work-related factors or relational dynamics between therapist and client that differ from personal relationships, that may act as moderating or mediating factors respectively, to attitudes. Limited and divergent findings, multiple scales used to elicit attitudes, in conjunction with variability in measuring the type of profession and setting reduce the ability to compare attitudes amongst professionals.

1.3.1.5 Aim 5: Demographics and attitude trends

A plethora of demographic information was collated and used to discern if this influenced attitudes towards transgender people. These include gender, sexual orientation, political ideology, religiosity, ethnicity, and age.

1.3.1.5.1 Gender

Here, overwhelmingly consistent data from seven studies report a significant difference between males and females. Regarding attitude, females are significantly more positive (Ali *et al.,* 2015; Bowers *et al.,* 2015; Riggs & Sion, 2016). When deconstructing this further, Riggs and Sion (2016) conducted two studies investigating the sole effects of gender on attitudes in samples of psychologists, social workers and counsellors (study one) and psychologists, counsellors, social workers, psychiatrists and mental health nurses (study two) respectively. Study one identified that females scored lower (indicating more positive attitudes) on the genderism/transphobia subscale of the GTS. In study two, using the CATTS scale, males reported less positive attitudes. The internal

reliability of this scale was high at $\alpha = .92$, although criticisms from the quality assessment emphasised failure to incorporate measures to assess gender role ideology, given the author's statement that Cisgender men invest in hegemonic masculinity[5] which leads to more negative views of transgender people. Thus, their results cannot confirm whether this factor or alternative factors included in this review mediate the relationship between sexual orientation, religiosity, and political ideology.

Bowers *et al.* (2015) add credence to these gender differences across settings with their sample of school psychologists ($N = 248$), also finding females possess more positive attitudes than males. In their sample, gender accounted for 2.3% of the variance of what we know about a person's attitude, although there were stronger associations with variables such as region, discussed later. Moreover, studies describe how females report higher levels of accurate clinical knowledge (Riggs & Bartholomaeus, 2015; Riggs & Bartholomaeus, 2016a), acceptance (Riggs & Bartholomaeus, 2015) and score higher on Interpersonal Comfort, Human Values and Sex/Gender Beliefs (Kanamori & Cornelius-White, 2017).

In contrast, two studies reported no significant differences in their sample of male and female counselling competencies of counsellors, psychologists and social

[5] Hegemonic masculinity is a concept proposed by Connell (1987) referring to gender order theory. This theory proposes males maintain their dominant position in society and justifies the subjugation of females and marginalization of males that do not conform to the dominant, binary, masculine view of male representation.

workers (Dispenza & O'Hara, 2016; O'Hara *et al.,* 2013). Both these studies used the GICCS; a modification of the SOCCS adapted specifically for the use of ascertaining views unique to transgender people. Of interest, Dispenza and O'Hara (2016) used a social desirability measure (SDS-17) although note that the group under investigation may be familiar with these scales and as such this may be less reliable.

1.3.1.5.2 Sexual orientation

Three studies investigated the influence of sexual orientation on attitudes. Although several studies asked about this information, not all utilised this as one of their factors in the analysis and is a general limitation of the papers retrieved.

While O'Hara *et al.* (2013) found that sexual orientation did not affect attitude ratings, Dispenza and O'Hara (2016) report significant differences between sexual minority groups (for this study, this is presumed as not heterosexual, although not defined explicitly). Their study from a national multicultural counselling conference found small to medium effect sizes on self-rated measures concerning more knowledge to work with transgender non-conforming (TGNC) clients, more affirming attitudes and increased adequacy in counselling skills. The extensive use of self-report raises considerable concern on the lack of objective or proxy measures that can confirm this, and should be considered a limitation of all the survey data discussed. Whilst anonymity should reduce the likelihood for false reporting, it fails to address self-bias using this measure.

Finally, Kanamori and Cornelius-White (2017) found heterosexuals in their study reported lower positive attitudes than all other sexualities. The paucity of data recorded in these studies requires more research into sexual orientation, although some of these findings suggest that sexual minorities may hold more positive attitudes as they too may have experienced marginalization.

1.3.1.5.3 Ethnicity

Similarly, contrasting evidence regarding ethnicity and attitudes is reported. Both Bowers *et al*. (2015) and O'Hara *et al*. (2013) found ethnicity was not related to measures of attitude within their samples. In opposition to this, Dispenza and O'Hara (2016) found ethnicity was significantly related to transgender counsellor's competency. Here, respondents who identified as a racial or ethnic minority were more competent.

Furthermore, Agee- Aguayo *et al*. (2016) found significantly higher reported mean values for individual preparedness to address transgender issues in their African- American/Black/African sample ($n = 3$). While this differed from the European American and Latino American groups ($n = 64$ and $n = 14$ respectively), it was not significantly different to the Asian/ Pacific American group ($n = 2$). The use of mean comparative data reduces the ability to draw conclusions about causation of findings, although the authors reflect it may relate to minority groups experiencing similar discrimination, and thus being more empathic.

1.3.1.5.4 Political ideology

Within these studies, the region of residence is translated to political ideology; respondents were separated into progressive versus conservative regions or were asked directly about their political leanings. The data suggests that respondents from progressive regions or those who align themselves with a more liberal political ideology have more positive attitudes (Ali *et al.,* 2015; Bowers *et al.,* 2015). Positive attitudes include support of transgender rights, awareness of local and national policy, support of LGBT rights, affirmative attitudes and interest in receiving additional training on transgender needs (Johnson & Federman, 2014). Only one study by Riggs and Bartholomaeus (2016b) found no significant difference in participants' state of residence and attitudes, and Riggs and Bartholomaeus (2016a) failed to report their findings. Non-significant results from both scales employed within Riggs and Bartholomaeus (2016a) study suggest that comparison to other research is limited.

1.3.1.5.5 Religiosity

Of all the studies to elucidate data on religious beliefs, a negative correlation with increasing religiosity and positive attitudes is reported. Thus, as religious beliefs increased, positive attitudes decreased towards transgender individuals. A variety of scales including the GTS, ATTIS, CATTS, and KATI substantiated these results. The sample ranged from school psychologists (Riggs & Bartholomaeus, 2015), mental health nurses (Riggs & Bartholomaeus, 2016a; Riggs & Bartholomaeus, 2016b) psychologists, psychiatrists, and, social workers (Ali *et al.,* 2015; Riggs & Bartholomaeus, 2016b). A criticism of all studies is a failure to

enquire about religious denomination to investigate which affiliation held more negative attitudes.

1.3.1.5.6 Age

Of the seven studies that investigated whether age influences attitudes, four found there were no significant effects (Bowers *et al*., 2015; Dispenza & O'Hara, 2016; Kanamori & Cornelius-White, 2017; Riggs & Bartholomaeus, 2016b). Of interest, Riggs and Bartholomaeus (2016a) report that older age is significantly associated with more clinical knowledge. Results from Johnson and Federman (2014) however, found younger participants held more positive attitudes. Of the studies reviewed, none investigated whether this is related to changing cultural attitudes and increasing visibility of transgender issues, with younger people having less exposure to traditional heteronormative frameworks.

To conclude, being female, being situated in a progressive state, with liberal ideology positively correlates to holding more positive attitudes. Religion negatively correlates with positive attitudes. Tentative suggestions regarding heterosexual participants being more likely to hold negative attitudes is suggested. Similarly, being an ethnic minority is also proposed to lead to more positive attitudes. Substantial divergence in findings regarding age reduces definitive understanding of whether this demographic data influences attitude.

1.4 Discussion

The aim of this review was to systematically assess existing research on MHPs attitudes towards transgender people. Attention was given to attitude constructs,

whether overall attitudes were positive or negative, whether training, education or experience influences attitude, whether differences exist between practitioner group, and, demographic variables that can affect attitudes.

Overall attitudes towards transgender people were positive which supports the existing literature of health care professionals holding more affirmative views in comparison to the general population (Nisley, 2011). Tolerant attitudes of health care professionals are unsurprising, given the perceived empathic relationships created with clients which provide meaningful interpersonal relationships (Hojat, 2016). Also, it is likely that medical professionals are more likely to encounter this population, which can provide opportunities to challenge biases or assumptions (Pettigrew & Troop, 2006).

However, negative attitudes were also present within the studies. Health care professionals have a code of ethics that invokes non-discriminatory practice based on multiple intersects such as gender, ability, race or social status (Nursing and Midwifery Council, 2015). Despite this, Giddings and Smith (2001) discuss how nurse's attitudes reflect societal attitudes including genderism, homophobia, sexism, and racism, and it is possible that these prejudices and discriminatory attitudes are not exempt from the samples reviewed. This suggestion cannot be stated definitively given the cross-sectional design of the studies.

The reported constructs of positive and negative attitudes derived from Hill and Willoughby's (2005) scale are consistent with previous findings as cited in Nisley (2011). As the data is primarily descriptive, in contrast to Nisley (2011), the

present research does not elaborate on factors that may influence this, such as practitioner's beliefs about origins of transgender presentation.

MHPs that had limited or no contact with transgender people reported more anti-transgender attitudes, as shown in Hill and Willoughby (2005) study. Increased personal familiarity led to more positive ratings and is consistent with the wider literature (Herek, 1994; Nisley, 2011). It remains to determine whether positive attitudes preceded this interpersonal contact due to the cross-sectional design of the studies reviewed.

Education on transgender-specific attitudes was found to be lacking across practitioner groups. The American Psychological Association Task Force on Gender and Gender Identity (2009) stipulate that issues of gender identity should be incorporated into training programs for psychology. Although the review found transgender-specific training led to contradictory findings on attitude (Bowers *et al.,* 2015; Kanamori & Cornelius-White, 2017; O'Hara *et al.,* 2013), it appears that training remains relatively inadequate in practice.

Findings from Johnson and Federman (2014) accentuate the importance of setting and organisational culture concerning attitudes. Their study reported 92% of participants did not enquire about gender identity, and a high proportion believed they had not encountered a transgender person. The culture of the US military prior to the repeal of *Don't Ask, Don't Tell* encouraged invisibility of TGNC people and sexual orientation. A plausible explanation for these findings could be

the failure to disclose incongruent gender identity due to correctly or incorrectly held beliefs about MHPs attitudes regarding homophobia or transphobia (Grant *et al.,* 2011; Shipherd *et al.,* 2010).

Despite individual studies comparing practitioner groups, this review cannot synthesize this data given the methodological limitations and failure to compare practitioner groups consistently across studies. Further limitations include the lack of qualitative data to explain the differences and emphasise a need for qualitative studies to expand the current knowledge on this issue.

Replication of demographic variables influencing attitudes are confirmed; a gender disparity was established with females reporting more positive attitudes as noted within the research (Hill & Willoughby, 2005; Nisley, 2011) and is comparable to other findings of a gender bias towards gay, lesbian and bisexual people (Herek 1994; 2002). However, it is beyond the scope of this review to determine whether this variable, when controlled for in comparison to other variables, remains significant. Only Dispenza and O'Hara (2016) explicitly report doing this, and in their study, this was no longer a significant predictor for positive attitude; instead, being a sexual minority, racial/ethnic minority and advanced career professional was a significant predictor to attitude. Future research should explore factors which underlie these findings, for example, a difference in empathy, compassion, or personal contact with transgender people, to further examine what may mediate this relationship between gender and attitude.

Collated findings suggest a more negative attitude if you are a conservative, male, heterosexual, religious or Caucasian MHP. In contrast, being female, an ethnic or sexual minority, liberal or less religious MHP indicates more favourable attitudes. One possible account for these differences may be experiences of belonging to a minority group, and thus, this population may hold more compassionate and empathic attitudes for transgender people's experiences.

Moreover, negative attitudes have been suggested to be related to holding hegemonic views on gender, specifically with males needing to maintain their patriarchal power (Connell, 1987). Hegemonic beliefs may also indicate why views towards Female to Male (FTM) transgender people are reportedly less negative (Bockting, Miner, Swinburne- Romine, Hamilton & Coleman, 2013; Wallien, Veenstra, Kreukels & Cohen-Kettenis, 2010).

The compilation of findings supports previous research showing religious beliefs, and conservative political ideology negatively correlates with positive attitudes towards transgender people (Rehbein, 2012). However, there may be mediating latent variables such as individual values that are responsible for this relationship and requires further inquiry.

1.4.1 Limitations of the literature

There are several limitations to the collated data which warrant further discussion. First, the quantitative data reported here predominantly relate to a white, heterosexual, Western population, with studies conducted in only three countries

(Canada, USA, and Australia) highlighting the need for multi-cultural and qualitative research. Generalisability of these findings is reduced, and results should be interpreted with caution. The failure to ascertain views from under-represented groups (non-white populations and sexual/ethnic minorities), especially since the intention of many studies was to compare such data, may reflect a difficulty in recruiting these populations or methodological flaws in the design of the studies under review.

Essentially, the quality of papers was mediocre; there was a dearth of interventions reviewed in this topic area, with only Kidd *et al*. (2016) providing follow-up measures. Given the importance of their findings, more longitudinal studies are required to evaluate specific facets that contribute towards sustainable attitude change. Many papers used comparative statistical analysis, and as a result, only relationships and their strength can be elucidated, as opposed to causation. The failure to employ social desirability scales is a major limitation of all studies except Dispenza and O'Hara (2016). Given the population under investigation and their familiarity with such research, it is possible that participants were more likely to rate themselves favourably, introducing a bias. However, Dispenza and O'Hara (2016) note that given the experience of the participants, social desirability scales may be redundant, and as such additional measures should be used to confirm the results, for instance, proxy information such as clients of the therapists, to aid reliability of the scores obtained.

Regrettably, only one study compensated for potential order effects (Dispenza & O'Hara, 2016). By prompting participants to report on gender, sexual orientation,

political ideology or religious beliefs before enquiring about attitudes, this may make attitudes more salient, and as a result, participants may be more negative. These findings may not be reflective of any conscious actions they would employ to combat these implicit attitudes. In contrast, findings of positive attitudes may be reflective of the tools that are used after activation of such beliefs. A failure of the current literature to investigate and distinguish between implicit and explicit attitudes of MHP may not accurately reveal how this translates into the therapist-client relationship.

1.4.2 Limitations of the systematic review

This systematic review was conducted in a rigorous way to ensure critical evaluation of existing studies focusing on MHPs attitudes towards transgender people. However, there are limitations which may have reduced the overall validity of the review.

The decision to include studies from 2010 onwards was a considered one; Dorsen's (2012) analysis of nurses' attitudes towards transgender people included papers until 2010. However, as the review did not state the month in which the data collection ended, it was prudent to use this as a starting point. The review, therefore reflects the most recent attitudes and evaluations into this area of research, given rapidly changing views towards the transgender population. Despite this rationale, it is a limitation that papers before 2010 were excluded as this may have elucidated further information on findings discussed.

Indeed, a decision to also not include grey literature means contemporary studies

referred to in the papers retrieved are not included (Nisley, 2011). For example, Nisley's (2011) findings offer credence for tolerant attitudes displayed within the counselling profession towards transgender people and discuss instrumental variables such as training, experience, and multicultural competency. These results could have enriched the present study. However, only peer-reviewed journals were selected to ensure the most robustly designed studies were included for the review. On reflection, quality assessment of the studies revealed grey literature may not have reduced the overall quality.

A final reflection of the papers retrieved is the conflation of the transgender community as a homogenous group. Except for the explicit reference of the GTS primarily eliciting attitudes towards MTF transgender people, the remaining scales appear to address attitudes towards transgender people as a collective group. Consequently, this review cannot make claims as to whether differences exist in attitudes towards MTF transgender, FTM transgender, or TGNC people. Recommendations for refined scales and future research could address this limitation.

1.4.3 Research implications

As previously acknowledged, failure to consistently utilise standardised scales limits the comparability of the data. Some authors adapted or created scales due to inadequate existing scales (Johnson & Federman, 2014; Riggs & Bartholomaeus, 2015), despite the TABS, or Bowers *et al.'s* (2015) adapted scale being used in earlier research. Future research should attempt to address this through utilisation

of scales with multiple populations to test the validity and reliability of existing scales.

Furthermore, most of the data reported here reflect investigations into the presence of negative or positive attitudes and demographic variables that influence this. Few of the papers reviewed provided the components that construct a positive or negative attitude. While several studies under consideration have sought to investigate associations between demographic variables and attitudes, to date, the impact on the interaction between MHP and transgender clients is neglected and requires further research.

Lastly, the transgender population is a heterogeneous group. With scales such as the GTS predominantly focusing on MTF transgender experiences, these cannot reflect accurate views across the transgender spectrum. Measurements that address specific subpopulations are likely to yield more accurate data. There is a critical need for higher quality measures that operationally define terminology of transgender and constructs of attitude factors (IOM, 2011).

1.4.4 Clinical implications

This present systematic review indicates variables can influence attitudes. Clinical implications to address this include:

- Psycho-education for MHPs focusing on an empathic understanding of gender flexibility and the social construction of gender roles is warranted.

Preliminary findings suggest this should be repeated after 90 days to sustain attitude change.

- To counter some of the fears regarding discriminatory attitudes within the transgender community, MHPs should be encouraged to engage in outreach work with transgender groups, fostering personal contact.
- A culture of alliance towards the transgender community should be promoted within organisations, which can provide a platform for trusting, sensitive, and, safe therapeutic spaces.
- Reflective individual supervision should provide a safe place for MHPs to explore their attitudes towards the transgender client group they serve. This may include guided reflection of their religious beliefs, political ideology, and gender, and how this converges or diverges with intolerant attitudes towards transgender people.

1.5 Conclusion

The purpose of this analysis was to critically evaluate and synthesise the literature investigating MHPs attitudes towards transgender people. Despite many of the papers being highly contemporary, the review highlighted numerous methodological flaws within the papers. Often utilising small, convenience samples without recognition of the wider population available, the literature is limited by reliance on inconsistent scales and various operational definitions of transgender people. The systematic review found instruments show inconsistent reliability or validity, and almost a complete failure to account for socially desirable responses.

Suggestions for future research are considerable. Increased understanding regarding latent variables which underlie some of the attitudes reported could lead to direct and targeted interventions for attitudinal change. Additionally, nuanced scales addressing the heterogeneous population of the transgender community would provide more clarity and accuracy regarding attitude responses. Future studies conducted in the UK would enhance cultural specificity regarding attitudes of MHPs and their transgender clients, and enable cross-cultural comparison with present findings. Perhaps most crucially, promotion of affirmative and positive attitudes alongside the formation of transgender alliances with the healthcare profession could lead to increased confidence in help-seeking behaviour for transgender people, improved clinical efficacy, and, outcomes.

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Chapter 2: Empirical Paper

Exploring the lived experience of transgender transition

Written in preparation for submission to the *International Journal of Transgenderism* (See Appendix A for author guidelines).

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2.0 Abstract

Aims: Transgender transition can be a fraught and life changing experience. Currently, there is scarce information on the subjective experience of the journey involved in recognition of oneself as transgender within a UK population. The present study aims to investigate the in-depth lived experience of embarking on transgender transition, and how this experience was hindered or helped through internal and external influences.

Method: Six male to female (MTF) self- identified transgender participants were recruited. Semi-structured interviews were analysed using Interpretative Phenomenological Analysis.

Results: Four superordinate themes emerged from the analysis: *Rudderless: "Journey of discovery a fraught one," Intersectional systems of oppression*, *Disempowerment* and "*Transitions to an authentic sense of self: learning how to live again.*"

Conclusions: Experiences of MTF transgender transition is considered within the existing socio-political context. Service implications and areas of future research are discussed.

Keywords: *Transgender, transition, mental health, male to female, Phenomenological, IPA*

2.1 Introduction

2.1.1 Transgender context

Traditionally, medical theoretical positions have conceptualized the term transgender within a discourse that describes individuals who do not identify with their anatomical sex assigned at birth (Hines, 2007; Singh, Hays &Watson, 2011). Recently, a more contemporary view published in the Diagnostic and Statistical Manual of Mental Disorders V (DSM-5; American Psychiatric Association [APA], 2013) introduced 'gender dysphoria' replacing the now defunct 'gender identity disorder' (APA, 2000).

However, literature consistently reports the dominant medical model prevails within society. Gender is considered an "invariable, biologically determined, binary phenomenon" (Burdge, 2007, p.355.; Markman, 2011; Nagoshi & Brzuzy, 2010) and thus exists within a heteronormative framework that does not account for the complexities of transgender experiences (Hines, 2007).

2.1.2 Mental health and psychological wellbeing

Marginalization and oppression of transgender people based on society's struggle to move away from a dichotomy towards gender fluidity is ongoing. A plethora of studies link these factors to reports of suicidal ideation in this population (Grossman & D'Augelli, 2006; McNeil, Bailey, Ellis, Morton & Regan, 2012; Testa, Sciacca, Wang, Hendricks, Goldblum, Bradford & Bongar, 2012; Xavier, Bobbin, Singer & Budd, 2005). To date, research reports the negative consequences associated with the process of "coming out": transphobic

harassment, physical, verbal and sexual abuse, and rejection from family, friends, and colleagues (Morton, 2008; Whittle, Turner & Al-Alami, 2007).

Moreover, Alkire *et al*. (2009) describe how transgender people are frequently discriminated against and experience an infringement of their rights, across various areas of their life. Consequently, Testa, Habarth, Peta, Balsam and Bockting (2015) aver that the disproportionate discrimination and the physical and sexual violence transgender people receive, contribute to the suicide attempts found in this group.

2.1.3 Trans-affirmative research

Contrasting evidence that "coming out" facilitates self-acceptance and contributes to acceptance from others, including a shared self-esteem within the transgender community, has been reported (Mizock & Lewis, 2008; Singh *et al*., 2011). In conjunction with this, Testa *et al*. (2015) propose that psychological wellbeing during transition can be enhanced by awareness of and engagement with other transgender people prior to and during one's transition.

Moreover, Burdge (2014) has extended the research into trans-affirmative experiences, describing those who feel liberated by their transgender identity. These participants felt that intimate connections with themselves, others, and a larger purpose helped to constitute the framework in which they lived fulfilling and meaningful lives post identification as transgender.

2.1.4 Rationale

Transition as a concept is vague, given that some individuals never identified with their biological gender role assigned at birth. Gender presentation and social roles are often assimilated when considering transition; extending beyond hormone therapy and surgery and include social signifiers of preferred gender identity such as pronouns or disclosing transgender identity to others (Coleman *et al*., 2011).

Regarding the timing of suicide attempts and gender transition, clinical studies and surveys have depicted transgender people at an elevated risk for suicide attempt before gender transition, with rates decreasing following transition (DeCuypere *et al*., 2006; Transgender Equality Network Ireland, 2012; Whittle *et al*., 2007). Other minority and marginalised groups recognize suicide as "expressions of social powerlessness" (Petchkovsky, Cord-Udy & Grant, 2007, p. 1), and thus highlight the need to conduct research into transgender experience, particularly transition and the factors which affect psychological wellbeing during this journey.

2.1.5 Research Aims

While transgender literature has increased over the past decade, there is a dearth of research providing insight into the UK based, phenomenological accounts of transgender transition experiences. This research aims to understand the subjective experience of the journey involved in identifying as transgender and the associated impact on one's mental health to guide clinical support and future policy for this increasingly visible group.

2.2 Methodology

2.2.1 Qualitative Approaches

Qualitative research is an 'umbrella' term, whereby several different approaches take a social inquiry into the way people make sense of and interpret their world (Atkinson, Coffey & Delamont, 2001). This study used a phenomenological approach to understand the lived experiences during transition for transgender people.

2.2.1.2 Interpretative Phenomenological Analysis

This research utilized Interpretative Phenomenological Analysis (IPA; Smith, 1996; Smith, Flowers & Larkin, 2009). In recognition that any methodological stance constructs reality as much as it describes it, this approach places the participants as experts of their experiences and attempts to give voice and make sense in a bottom-up approach that avoids generating theories (Larkin & Thompson, 2011; Taylor & Bogdan, 1998). IPA is an established methodology for reflecting the experiences of those undertaking a life transition, and the most suitable option to cluster similar categories of experience which represent the core commonality within the identified sample (Starks & Brown-Trinidad, 2007; Smith *et al.,* 2009).

2.2 Participants: Inclusion and exclusion criteria

In line with guidance from IPA methodology, a small sample of participants was selected, initially allowing for ten and recruiting six. Inclusion and exclusion

criteria and participant demographic information are shown in Table 2.1 and Table 2.2 respectively. Psuedonyms were chosen to protect participants' anonymity.

Table 2.1 Inclusion and Exclusion criteria

Inclusion criteria	i.	Male to Female transgender
	ii.	Aged 19 +
	iii.	Transition post 1980
	iv.	Transitioned at least 12 months prior to study participation.
	v.	UK based
Exclusion criteria	i.	Non-English speaking

Table 2.2 Participant characteristics

Participant	Age	Length of transition (years)	Stage of transition	Gender identity	Perceived by others	Use of services
Alice	43	5	Undergoing gender reassignment	Uncertain of gender	As the gender I identify with	GP Antidepressants Therapy-private
Serena	43	3	Undergoing gender reassignment	Clear and constant gender identity as a woman	As the gender I identify with	Therapy-NHS Therapy-Private University Counselling Service
Catherine	22	2	Undergoing gender reassignment	Transgender	As the gender I identify with	GP
Holly	34	9	I have undergone the process of gender reassignment	Clear and constant gender identity as a woman	Transgender	GP Therapy-NHS Antidepressants
Anna	43	7	I have undergone the process of gender reassignment	Clear and constant gender identity as a woman	As the gender I identify with and Transgender	GP Therapy-NHS Community Mental Health Team

2.2.3 Procedure

2.2.3.1 Ethical procedure

Ethical approval was granted from Coventry University on 15th January 2016 (Appendix F). The research adheres to the British Psychological Society's guidelines (BPS, 2010).

2.2.3.2 Materials

A semi-structured interview schedule was designed (Appendix G) in accordance to guidance by Smith *et al.* (2009). A semi-structured approach balances guidance of the topic under investigation whilst also allowing flexibility for the participant to share their experiences and the researcher to follow up on interesting lines of inquiry or salient experiences.

2.2.3.3 Recruitment

Recruitment utilised a purposive sampling method in recognition of the population being difficult to access as a vulnerable or hidden minority group (Kenagy, 2005; Smith & Osborn, 2003; Vogt, Gardner & Haeffele, 2012). Advertisements were made in 'The Gay UK' magazine and flyers were distributed during Manchester Sparkle (a recognized Trans celebratory event; Appendix H).

Initially 23 participants registered interest responding by email to the aforementioned advertisements. Participants were sent an information sheet (Appendix I) and demographic form (Appendix J).This initial phase excluded 11 potential participants; three resided outside of the UK (Ireland, USA, and Denmark respectively), six did not respond, one person did not specify which

criteria they did not meet and one person identified as intersex. Of the twelve remaining participants, six people accepted interview dates.

2.2.3.4 Procedure

Interviews took place between March 2016 and July 2016. Location of interview varied on the preference of the participant and included participants' home (n = 3), university premises (n = 2) and a public setting (n = 1). Interviews lasted between 107 minutes and 169 miutes (M = 122 minutes) and were audio recorded.

Participants were asked to review the information sheet again. Time was spent exploring questions related to the research and following this informed consent was obtained (Appendix K). In recognition that some interview material may elicit unintended distress, participants were provided with information on appropriate support services within the debriefing sheet (Appendix L) and offered another opportunity to ask questions.

All six participants submited contact details, an option offered if they wanted to participate in respondent validation and obtain details of the outcome of the empirical research. Participants were reminded they had two weeks post interview during which they could withdraw from the study.

2.2.4 Analysis

Audio recorded interview data was transcribed as proposed by Smith *et al*. (2009) and identifying information was omitted or substituted. The researcher kept a reflective journal at each stage of the analysis to aid reflexivity. The IPA analysis

procedure, examples of extracts from coded transcripts and a visual map of superordinate and subordinate themes can be found in Appendix M (Table 2.4), Appendix N and Appendix O respectively.

2.2.4.1 Validity and credibility

Data verification was completed with a second member of the research team to assess emerging themes. Validation of superordinate themes, content, linguistic and analytical coding alongside reflections were shared. Next, credibility of the findings was confirmed through respondent validation (Mays & Pope, 2000) with the researcher providing participants with summaries of superordinate and subordinate themes (see Appendix P).

2.2.4.2 Researcher's position

Recognising the impossible task of remaining neutral and objective, the researcher's position is crucial in the validity of the research. Therefore, reflexivity is key in acknowledging my own etic perspective (Harris, 1976; Smith, 1983). As Smith *et al.* (2009) aver, my own fore-conception is brought to the encounter; my identification as a white, middle-class, heterosexual, (feminist and science educated) female will influence the interpretation of the data. As such, a bracketing interview was conducted alongside measures of self-reflexivity to consider the stance in which I view the cultivation and intersects of gender (Finlay, 2008).

Within the research, I have taken a social constructionist perspective, which encourages a cautious and critical approach to the world view through our own

subjective lens. It recognizes that we are reliant on language to communicate and convey our experiences, but that knowledge is rooted in cultural and historical specificity (Burr, 2003; Lock & Strong, 2010). This stance is congruent with my own personal epistemology.

2.3 Results

Following data analysis, four superordinate themes emerged: *Rudderless: "Journey of discovery a fraught one"*, *Intersectional systems of oppression*, *Disempowerment*, and "*Transitions to an authentic sense of self: Learning how to live again*". All superordinate themes have subordinate themes and are displayed in Table 2.3. Throughout the results, convergence and divergence of narratives is considered.

Table 2.3 Superordinate and subordinate themes

Superordinate theme	Subordinate theme
Theme 1. Rudderless: "Journey of discovery a fraught one"	a) "I didn't know what I was until I had a word for it" b) "A forged persona" c) "I am endlessly becoming"
Theme 2. Intersectional systems of oppression	a) "Become the man I was expected to be" b) "Losing contact with your origins is huge" c) "They can hurt you, murder you" d) "Expectation of conformity"
Theme 3. Disempowerment	a) "I didn't feel like I was a real human being" b) "I just couldn't live as anything" c) Coping: "Why would I want to kill myself when the difference is living as myself"
Theme 4. "Transitions to an authentic sense of self: learning how to live again"	a) I am seen therefore I exist b) "It should have been this to begin with" c) "An educational phase in what being a woman means to me" d) "Doors started opening"

2.3.1 Theme 1: Rudderless: "Journey of discovery a fraught one"

All participants reflected on the nuanced and evolving process of transition; through reflections of their gender discovery to embarking on the multifaceted and "unique" journey of transition. This superordinate theme contains three subordinate themes, "*I didn't know what I was until I had a word for it*", "*We all just want to belong to something*" and "*I am endlessly becoming*".

2.3.1.1 Theme 1a: "I didn't know what I was until I had a word for it"

Five participants reflected on their experiences of invisibility of transgender issues. This often emerged early in childhood and was exacerbated by the lack of language comprehension at this age:

> "*I didn't know what I was until I had a word for it, I just thought I was broken…we all yearn for a sense of identity… I didn't feel Pakistani, I didn't feel English, I didn't feel like a boy, I didn't feel like a girl…I didn't understand what was going on*."
>
> (Serena, lines 285-288)

Serena describes the confusion at her limited understanding without a language to convey her experience, and additionally how this left her with no sense of belonging. The use of the word "*broken*" demonstrates her internalisation of the confusion as something fundamentally wrong with her.

Serena, Catherine, Anna and Katy reflected on how this time of confusion was further compounded by the narrative of transgender issues within the media

placed on a continuum, from absence in social consciousness, "*way back in the dark ages…no information on anything*", to mockery as it "*was treated like a joke*" or polarisation of transgender being deviant, with Alice discussing how she felt "*wrong, dirty, a pervert*".

The lack of role models through the distortion of transgender visibility led to confusion and fear for all participants, as reflected in Anna's account:

> "*There was no-one to compare to, to look up to, to see…all this confusion, and fear of saying anything, or just being different*."
>
> (Anna, lines 57-58)

Conversely, whilst Catherine did not have the same exposure to these historical representations of transgender constructs, she demonstrates how "*the internet has liberated Trans people*" through a shared platform of unity and belonging:

> "*We're always on social media and Twitter and YouTube and watching and learning off other Trans people*."
>
> (Catherine, lines 589-590)

The use of social media enables a safe space for advice and provides role models that can be utilised for support and coping.

2.3.1.2 Theme 1b: "A forged persona"

All participants reflected on the parallel process that transgender invisibility had on their own presentation; feeling as though their identity needed to be concealed. For example, Catherine talked of how she was trying to be herself "*behind closed doors*", similarly, Katy commented on how she was carrying "*this big secret*".

Holly recalled living a "*double life*" with her portrayal of a male persona during the week, yet expressing her female identity on holiday. This led to a "*crash*" when she had to "*revert to being him*". With the male pronoun, Holly conveys a distancing from ownership of the male identity.

The precarious nature of self-expression of female identity meant that the stark contrast of returning to the 'imposter' state of male identity was accentuated, as Anna describes:

> "*It was just upsetting because you had to go back to putting this act on. You knew you couldn't be you for another six days, sort of like going to prison I imagine…this box of being male and trying to be masculine and overcompensate*."
>
> (Anna, lines 265-268)

Anna's analogy of the male form being a "*prison*" perhaps depicts a struggle between feeling criminalised in the deception and trapped in conforming to the "*masculine*" role expected of her. The description of the "*box*" could also refer to the compartmentalization of her identity through this "*act*" where the focus is on performativity for others.

As a way of coping with feared social judgements, four of the participants described how they took on a "*parody*" of male identity. For example, Serena explains how her "*hard core self-conversion therapy*" left her a "*brute*" when she was "*pretending to be a guy*". Likewise, Holly described how she '*buried [herself] deep, deep into very masculine territory*". This description of a "*burial*"

suggests a death of the self by portraying the male role, thus creating borders of "territory" between genders.

However, self- expression often came at a cost for participants: cycles of shame and guilt followed, with Holly describing the consequences of dressing in clothes that "*give you a connection to who you want to be*":

> "*Not being able to get the clothes off quick enough and scrubbing my face raw to get the makeup off and almost to the point of being physically sick, that's how deep the shame was and the guilt*."
>
> (Holly, lines 82-83)

This was a shared experience that appeared to build in intensity and contribute to the psychological distress that participants felt as Serena highlights:

> "*Buy clothes and then just purge them, set fire to them and burn them again and again and again from shame and self-hatred, just wishing I would die really*."
>
> (Serena, lines 314-316)

The cyclical nature of shame is emphasised here within Serena's repetition in the frequency of the purges. Purging also suggests a need to expel the female identity from herself. This reaches a crescendo with her suicidal ideation from the internalised hatred.

2.3.1.3 Theme 1c: "I am endlessly becoming"

Transition varied with the "*unique*" experience being the commonality of participants' accounts. Katy described it as a "*slow process,*" and for Catherine it was one of several "*milestones*"; both interpreting transition as existing within a

time frame. In contrast, Holly's description describes a paradox of ever evolving transition which at the same time feels completed:

> "*I think there's still parts of me that are yet to come…I feel Cisgender because Cis means on the right side of and I feel that I'm absolutely on the right side of everything now."*
>
> (Holly, lines 870-887)

For Holly, transition has completed, being transgender is "*a phase in [her] life*. She is now beginning to explore the "*window of time*" whereby she considers herself Cisgender and during which she can become "*the true [her]".*

A striking observation that demonstrated the importance of how the concept of transition can evolve over time came from Alice:

> "*It's constantly evolved, I can think of several periods in therapy where I said no way would I manipulate my body, taking bits off, pumping myself full of chemicals and here I am ten years later and some of that's come to pass*."
>
> (Alice, lines 208-211)

Changes in the expectations of one's own transition highlights the fluidity of gender expression continuing post transition, given that transition is an "*organic*" development that will vary over the course of time and life stage.

This sense of continual personal learning and impact of complexity in transition on the self was shared through Serena's experience:

> "*The transition is not just a physical one; it's an emotional one, cultural one and it is my own sense of identity. Transition's not just from me knowing myself and accepting myself as a woman but it transitions to an authentic sense of self, a more authentic sense of expression…there's multiple different transitions for me*."
>
> (Serena, lines 631-636)

For Serena, there are interrelated aspects to transition that challenge the reductionist approach often conceptualised within modern-day medical interpretations of transition. Transition has encompassed all areas of her being, transcending the physical alterations and is interconnected to her intrapersonal style of relating.

2.3.2 Theme 2: Intersectional systems of oppression

All participants reflected on the layered intersectional experience inherent in discrimination and lack of privilege; subjected to societal and cultural constructed ideals of females, compounded by patriarchal power. This superordinate theme includes four subthemes "*Become the man I was expected to be*", "*Losing contact with your origins is huge*", "*They can hurt you, murder you*" and "*Expectation of conformity*".

2.3.2.1 Theme 2a: "Become the man I was expected to be"

All participants discussed the internalised difficulty of feeling confined by society's expectations in which they "*try to force gender upon you*". This

occurred through "*pressure*" and being "*expected to behave in a certain way*". Anna and Serena explain:

> "*Either everybody and everything in the world is wrong or I am and it's hard to fight at when you're six."*
>
> (Serena, lines 144-145)

> "*The impression I got from society was that it was wrong, it didn't feel wrong in my basic instinct, it wasn't wrong but outside pressure, society said it was wrong. It was a very transphobic, homophobic society*."
>
> (Anna, lines 115-116)

Again, age from theme 1a is key in processing these feelings of oppression, as it simultaneously highlights the gender constructed values implicit within societal discourse that is conveyed and internalised at this young age.

For Alice, contemplation of the difficulties unique to MTF transgender experiences, demonstrated how she believes men in society view this as shunning "*the team*":

> "*Why would a man knowingly give up his patriarchal privilege, his rights, just to become a female? Whether we like it or not women are still seen as second class citizens*."
>
> (Alice, lines 75-77)

Alice's comments highlight the power differential that exists within society where females are "*second class citizens*". The use of the word "*just*" implies a disdain

for females and the decision to transition inherently requires a loss of power and privilege imbued upon males as a birth right.

2.3.2.2 Theme 2b: "Losing contact with your origins is huge"

Prejudice and rejection became explicit within familial and friendship relationships, for all participants upon transition to varying degrees. For example, divisions in responses between both parents emerged for Catherine:

> *"[Dad] doesn't like it, he doesn't know what it is, he's not researched into it…[Mum] just accepted it, she's just lost a son but gained another daughter."*
>
> (Catherine, lines 514-542)

Catherine highlights a common difficulty for participants: the visible lack of transgender knowledge for family and friends which often made the process of transition more complicated. In addition, polarised opinions of parental responses to feeling they have "*lost a son*" created divisions within the family, indicating perhaps a diverging ability for fathers and mothers to process their child's transition.

Comparably, Katy described her process of "coming out" being taken as "*shattering the family*" with her mum responding by "*sticking in guilt trip pins*". The "*pins*" being stuck into her could be representative of a power imbalance as she becomes victimised through language and use of guilt, but additionally, the emotional abuse becomes embodied as a physical experience.

Finally, Serena spoke of the abuse she received as a result of "*being deviant*" when expressing herself through clothing:

> *"I was there at least because even when somebody is beating me up it was better than just disappearing… at least when I'm being hit I'm being noticed, I'm a part of something that's painful."*
>
> (Serena, lines 263-272)

Despite the physical "*beating*" she would receive from her father, Serena's reflections epitomise how the ultimately feared consequence is "*disappearing*". The abuse, although a painful experience acknowledged her existence and this reflection enabled her to move away from an internalised sense of depravity to understand why she would not "*retreat and hide*" from these painful encounters.

2.3.2.3 Theme 2c: "They can hurt you, murder you"

This notion of discarding one's power and privilege by deciding to transition poses additional consequences of oppression as Serena discusses:

> *"There's a hyper-sexualisation that therefore I must be a desperately sexual being because I identify as a woman and there's the de-sexualisation of who would ever want to be with that? Because you're not a woman so it's kind of like this weird position where it often gives men a relief that they are right and it's OK to be sexist but also not even treat you as they would a woman because you're not really a woman."*
>
> (Serena, lines 772-776)

Serena captures many participants' accounts of abuse received from the public. Here, she grapples with Anna's earlier account of patriarchal privilege, yet despite being a "*second class citizen*" there is an inference that a person of transgender experience is further debased.

Both Serena and Catherine emphasised how being "*clocked*" as transgender in the community can lead to danger:

> "*That's when it gets dangerous: they can hurt you, murder you, shoot you, knife you, stab you. There's been a lot of violence and stuff in America where people have been murdered because they're Trans*."
>
> (Catherine, lines 1088-1089)

In Catherine's account, the dangers that others pose for her identification and group belonging as transgender is rooted in reality with media portrayals of violence and death. Her repetition of the word "*you*" is perhaps an attempt to invite the researcher into her discourse and by proxy her experience through empathy.

2.3.2.4 Theme 2d: "Expectation of conformity"

Parallels of expected conformity between the Cisgender community and transgender community emerged in Alice, Anna, Holly and Catherine's descriptions. Anna described one aspect of this as "*passing privilege*", a term that describes being able to "*pass as a Cisgendered woman*". Katy described the pressure inherent in this:

"I don't like the word passing, it's got connotations of a test to it."

(Katy, lines 19-20)

The pressure to "*conform to the Transvestite standard*" was felt by Holly when she attended support groups during the early stages of exploring her identity. Alice captures some of the group expectation of conformity:

> *"We have a responsibility, if we want to be taken seriously we all have that responsibility, we can't just expect society to go oh come on then we love you, why not? Why would we?They've got to see we're worth accepting and just being ourselves where it doesn't look like we've made much presentation or effort it's gonna just give the wrong message."*

(Alice, lines 829-833)

Alice's "*responsibility"* to be "*taken seriously"* is reminiscent of moving away from the "*mockery"* that transgender ancestry has historically held. Perhaps in people's variance of *"presentation",* this creates a fracturing of the group identity and thus expectation of conformity is highly regarded to ensure in-group boundaries.

Alice tries to reconcile the difficulties in loss of a Cisgender developmental period, later mentioned in theme 4c, with the impact this has on being perceived as *"cross-dressed".* This is a term connected historically to transgender expression but often holds connotations of the "forged persona" or being linked to sexuality or fetishism:

"You can tell the Trans women that haven't had the input because they look cross-dressed (laughs). But you can understand it, they've not grown up with a peer group, they've not had the sister to show her makeup … so they bodge it through and it shows."

(Alice, lines 817-820)

2.3.3 Theme 3: Disempowerment

Consequently, the above theme evoked feelings of powerlessness in all participants, exacerbated by the transition pathway and psychological impact of prejudice and discrimination. This superordinate theme includes the subthemes: "*I didn't feel like I was a real human being*", "*I just couldn't live as anything*" and Coping: "*Why would I want to kill myself when the difference is living as myself*".

2.3.3.1 Theme 3a: "I didn't feel like I was a real human being"

Five participants who had embarked on the Gender Identity Clinic (GIC) pathway, described a system that served to disempower and "*cause more depression than anything*":

"*Cisgender people don't understand what it's like… I had no control over my treatment half the time…they were in control of my life and were making judgements on my behalf that I should be making."*

(Holly, lines 725-730)

Holly's description of "*Cisgender people*" could have a double meaning: firstly, the generic term "*people*" creates a faceless system that is not held accountable, secondly, it highlights Cisgender people's inability to comprehend the "*struggles*

a Trans person goes through". The importance of transition is depicted in how this pathway is more than "*treatment*", as it determines her "*life*". The lack of agency is explicit in the inability to be involved in decisions.

The pathway delays were of concern to Katy and Alice. Katy described attending her GP surgery and meeting a "*nonplussed*" doctor. This unhelpful experience led her to "*crawl under a stone for another five years*". The lack of societal awareness of transgender issues on the frontline, increased demand on the waiting list, and, delays to transition expose the "*abysmal service*".

Finally, Alice concedes the powerlessness inherent within her position:

> "*The transphobic stuff that goes on in some of these services is unacceptable. But, the trouble is you say something who gets penalised? It's the person that gets penalised…I mean I lost four months last year…erm no you can't talk*."
>
> (Alice, lines 460-463)

While in a position of relative dependence on the GIC pathway, Alice's account describes the prospect of punishment through manipulation of access to services and thus she remained silent despite being subjected to hate crime.

2.3.3.2 Theme 3b: "I just couldn't live as anything"

Years of "*internalised self-hatred*" and external influences that prevented gender expression led to a variety of mental health difficulties including rumination,

dysphoria, depression and anxiety. This culminated in suicidal ideation for all participants, depicted in Catherine's account about her life prior to transition:

> "*All I saw was a rope with a loop hole in it, and in this loop hole I just saw green fields and trees and stuff, whereas outside the loop hole I just saw grey boxes …inside the loop I just felt free*."
>
> (Catherine, lines 1132-1135)

Catherine's desperation and desolation had reached a critical point in which suicide appeared to be an option that could give her the freedom she craved. The notion of a bleak "*grey*" life outside of the rope perhaps represents her disconnection with the wider world. The "*boxes*" could hold a dual representation of a coffin box in continuing to live this way, or, the oppression of having to fit into gender boxes. In contrast, death held what appeared to be a vivid and serene scene.

Furthermore, Anna describes how, after a failed suicide attempt, she regressed to a complete reliance on her parents, due to the debilitating presentation of her depression:

> "*Everything's spinning round…you're in this whirlpool and you can't look up because you know at some point this whirlpool is gonna close in on you…you've got this impending doom that you're going to drown."*
>
> (Anna, lines 523-528)

The metaphor of her depression being a "*whirlpool*" is evocative of her disorientation and distorted reality. Anna's helplessness in this situation is

captured in her tormenting account of the "*impending doom*" she experienced and fear of what may be above her if she dares to "*look up*".

All participants could express the external origin of these problems and a clear sense of the "*pathologising culture*" of Trans people:

> "*The outside influences of societal problems, hate crime, the system…being transgender shouldn't cause depression but it's the other influences and aspects of being transgender that make you depressed*."
>
> (Holly, lines 504-506)

Holly's insight into her distress as a direct result of gender expression conflicting with contemporary normative gender ideals disentangles this from an internal pathological origin. Despite the "*situational*" context of her difficulties, it demonstrates the fragility and vulnerability of a marginalised population during this process.

2.3.3.3 Theme 3c: Coping: "Why would I want to kill myself when the difference is living as myself?"

In a display of the "*mixed bag of tricks as one grows up*", participants drew upon a variety of coping mechanisms to support their mental health and wellbeing. These included positive intrapersonal mechanisms such as activism, self-expression as mentioned in Theme 1b, and exercise for Serena, Catherine, Holly and Anna:

> "*You're concentrating on riding the bike and you don't think about anything else."*
>
> (Catherine, lines 341-342)
>
> "*Anything that was a problem, by the time I'd had a run I'd come back and it was gone*."
>
> (Holly, lines 555-556)

The relief often came from having an external focus, providing respite from the "*dysphoric haze*", which left the mind "*splintering and vibrating between two*".

In addition, interpersonal relationships such as support from therapists, family, peers, as well as the transgender community, provided a safe base to explore difficulties:

> *"She was my shoulder to cry on…when I was transitioning that network was always supportive*."
>
> (Katy, lines 311-313)

All participants spoke of the importance of having a secure and safe person who they could, share the "*phenomenal journey*" that contains both "*low points*" and "*amazing highs*" with. It appears that having at least one person to confide in, alleviates some of the distress and "*burden*" experienced by participants.

With hindsight, Alice, Serena and Katy accepted that more "*risky behaviour*" had helped them "*distract*" or "*dissociate*" from their daily struggle to function before transition, including drugs and alcohol. However, Alice demonstrates how perhaps the ultimate way of coping was her ability to connect with her identity in

a way that enabled expression and facilitated her move away from those maladaptive coping mechanisms; transitioning:

> "*I finally stopped drinking erm so the only thing then was to start living and that was doing this."*
>
> (Alice, lines 593-594)

Her decision to transition is synonymous with an ability to "*start living*", Alice has been able to cast aside the mechanism that was helping numb her "*existence*".

2.3.4 Theme 4: "Transitions to an authentic sense of self: Learning how to live again"

This superordinate theme centres on the consequences of transition and the impact this had on participants' physical and psychological wellbeing. This contains the subthemes "*I am seen therefore I exist*", "*An educational phase in what being a woman means to me*", "*It should have been this to begin with*" and "*Doors started opening*".

2.3.4.1 Theme 4a: I am seen therefore I exist

A striking theme across all accounts was the need for social recognition from others to reinforce participant's own sense of identity. Alice highlights this when she considers the impact of meeting people for the first time:

> "*I'm gonna get looked at and what am I going to be seen as?"*
>
> (Alice, lines 854-855)

The focus on the reflected self-image was shared by Serena who spoke of the "*emotionally and psychologically jarring*" impact of her mirror reflection. Her fears are captured:

> "*The most difficult thing for me was the idea that I would transition and then I still wouldn't be perceived as a woman."*
>
> (Serena, lines 482-483)

Although an internal congruence with her sense of identity existed, the incongruence of her reflected appraisal was stressed as the main cause of difficulty and led to facial surgery. This was a shared concern of Katy, who attributed her decision to transition to the importance of reflected appraisal:

> "*Your sense of identity is central to more or less everything you do and if that is being misread you can get to a point where you don't feel you belong anywhere."*
>
> (Katy, lines 186-189)

Despite an internal sense of female identity, Katy foregrounds the importance of validation from others to share in her acceptance of identity through their interpretation of her presentation. The need for social recognition eclipses internal understanding and perhaps connects to the wider need for social belonging.

2.3.4.2 Theme 4b: "An educational phase in what being a woman means to me"

Four participants acknowledged a period of self-discovery occurring through a "*second puberty*" and experiential female interaction. For example, Anna reflects on the pleasure of her developing female form:

> "*It's just learning where everything is again…it's something totally new… cause you knew your body before, you lived with it*."
>
> (Anna, lines 823-824)

This period of rediscovery posits the physical body as a new entity. The shift to past tense "*knew*" when reflecting on her body cements her internalised sense of this being a novel physical form.

Similarly, Serena discusses how she "*didn't realise this could get better*", deconstructing the differences between female and male bodies and having to "*relearn and unlearn*" herself. It appears a paradox occurs of knowing yourself intrinsically, yet becoming acquainted to a new self, following physical adaptation. This is in stark contrast to Alice who found the physical development "*underwhelming*" and "*just what needs to happen*". This reflects the grief discussed in the next theme because this is "*many, many years late for me*".

The environment appeared to either facilitate or hinder this experience for participants, as Holly describes:

> "*That job helped shape me and who I am now a great deal; it enabled me to explore who I truly was because I was in a more female environment*."
>
> (Holly, lines 466-467)

Holly's description of experiential discovery of who she "*truly*" is echoes Theme 1b, alluding to a false sense of self prior to discovery of the "*authentic*" self. This

was juxtaposed against her previous male dominated environment where she felt she "*reverted back to being him but just living as a woman*".

2.3.4.3 Theme 4c: "It should have been this to begin with"

Loss was a particularly poignant subtheme with participants reflecting on the developmental stages that a biological female would have experienced, but one they missed. Holly expressed how she felt her life "*halted*" as she spent "*20 years where it was just an existence*". Similarly, Alice recognised this profound sense of loss:

> "*It will only go so far. I was never brought up as a female child, I've never gone through all the things a female adolescent would go through*."
>
> (Alice, lines 68-70)

This failure to have an identity-congruent childhood is described as hindering Alice's potential, leaving her limited in what she can achieve at this stage. This loss was embodied as physical pain when in contact with females prior to transition:

> "*This feeling of utter loss and dread would just wash through me. It was hot. It hurt; it was like stinging, you know if you've been sweating and your skin dries and there's that skin tightness*."
>
> (Alice, lines 103-105)

Loss extended to all facets of life stages, as Anna reflected on the "*things you learn as a child, girls learn as children*" which had eluded her, through to roles of female identity such as bearing children, as both Anna and Katy contemplated:

> "*It's not 10 out of 10 cause I'll never have a kid, never have a child and there's certain things that I'll never experience."*
>
> (Anna, lines 927-928)
>
> "*I could kind of give the impression I was pregnant which was something that helped…but again it got to the point where I knew I couldn't have kids and then just rationalised it as that."*
>
> (Katy, lines 833-836)

Both accounts show how transition provides an opportunity for reflection and a space to grieve the losses that were never experienced through the binary of gender constructs and biological differences. Whilst, transition alleviates some distress, it emphasises the grief over the lack of experiential learning associated with Cisgender development and offers support for early transition.

2.3.4.4 Theme 4d: "Doors started opening"

Participants reflected on the self-growth across different spheres of their life including happiness, agency, empowerment and their future. For Catherine, it was the decision to begin transition and "*come out*":

> "*I was in a well of fear and I just didn't know what the hell to do but as soon as I came out that death trap, I just strived…I just grew as a person*."
>
> (Catherine, lines 83-85)

The reference to being trapped within a "*well*", "*hell*" and "*death trap*" highlight the bleakness and insufferable nature of her life prior to transition. Having

disclosed her desire to transition, she now thrives with space made for her continued growth and actualisation as a person.

Moreover, Katy, Anna and Holly focused on their connectivity to themselves and others through the process of transition:

> "*I'm more positive about myself, I'm more positive about the world around me*."
>
> (Katy, lines 665-666)
>
> "*I've gained some more friends and I think that's because I'm a better person*."
>
> (Anna, lines 803-804)
>
> "*I have an opportunity, an opportunity to change things, I have an opportunity to benefit the world and benefit society, whereas I feel I haven't done any of that up until this point*."
>
> (Holly, lines 899-901)

All three participants highlighted their improved self-other relational skills following transition. Holly's repetition of "*opportunity*" emphasises the prospective sense of integration within society she now experiences. This contrasts with many participants' description of feeling "*isolated*" in their "*own little bubble*" prior to transition, or how [their] life had "*literally halted*".

Essentially, all participants acknowledged the importance of knowledge on Trans-ancestry and activism, drawing on a coping strategy from Theme 2d in facilitating their own self-esteem and confidence. Serena, discussed how "*knowledge is useful*

to express power and thus agency". Being an "*activist and academic*" enabled her empowerment in knowing her own rights especially when a "*trans woman of colour*" has little "*legal recognition"* highlighting multiple intersectionalities that have impacted on her experiences.

2.4 Discussion

2.4.1 Discussion of findings

This study revealed the lived experiences of transition in a diverse sample of MTF transgender population. Four themes emerged forming a causal progression of confusion and incomprehension of gender identity within a binary system to gender embodied expression, breaking conventional norms and was subjected to implicit and explicit societal negation of one's gender. Through disempowerment, resulting from intersecting systems of discrimination and lack of privilege, participants navigate a variety of mental health difficulties, sustaining these hardships to emerge into a more self-authentic, fulfilled identity following transition.

2.4.1.1 Theme 1: Rudderless: "Journey of discovery a fraught one"

A mosaic of life narratives validated the varied conceptualisation of one's own gender identity and how gender identity is embodied. This included 'transgressive' transgender identity (dismissive of binary gender categorisation), and more 'conventional' transgender identities (hegemonic constructions of gender as binary and a desire to embody the female identity; Namaste, 2005). This research supports gender identity existing on a continuum. Consistent with

previous research, all accounts challenged the assumptions of a "fixed and immutable relationship of sex and gender identity" (Elliot, 2009; p. 12), whilst reflecting a heterogeneous community.

Participants described an evolving transition process for themselves, and thus the term transition raises inquiries to its validity. Given the multiplicity of transition experiences, divergence should be conveyed to people embarking on this process. As such, mental health input may be required at different points of the journey and transition may not have a definitive end for some transgendered people.

2.4.1.2 Theme 2: Intersectional Systems of Oppression

Findings demonstrated how a societal consciousness that colludes with an essentialist, heteronormative framework of gender can place MTF transgender in a position of relinquishing their male privilege but not be considered "real" women (Heyes, 2003, p.1115). This is in support of Hausman (2001) who expressed dissatisfaction with the social constructivist theory of gender and with promotion of gender-role stereotyping built on assumptions of male and female categories, regardless of plurality of gender identities. A varied conceptualisation of gender identity highlights how group collective identity can be fragmented by differing beliefs.

Pressure within the transgender community to perfect a feminine persona to attain "*passing privilege*", exemplifies a continuation of historical difficulty (Gagne, Tewksbury & McGaughey, 1997; Gagne & Tewsbury, 1998). This parallel process of conformity to a hegemonic system was highlighted in areas of

employment and assumptions from what participants anticipated at the GIC. Whilst passing privilege reduces the exposure for abuse and harassment from the public, it also coincided with the theme of reflected appraisals. The positive reinforcement attained from feedback mechanisms of wider society was integral to all participants' sense of belonging, affirmation of their own identity, and self-esteem.

Rejection from familial and friendship groups is consistent with existing findings (Grossman, D'Augelli, Howell, & Hubbard, 2005; Morton, 2008; Whittle *et al*., 2007). However, participants' access to at least one form of supportive relationship (therapeutic, friendship, familial or community) was crucial in fostering increased positive wellbeing, and facilitated coping with transition. These findings warrant additional attention to support these nurturing relationships given the crucial role they promote.

2.4.1.3 Theme 3: Disempowerment

Fragmentation of a collective identity can further disempower an existing marginalised group. Commonalities not differences are often what form the social glue between in-group and out-group membership. Considering this, one wonders whether the continued disempowerment of transgender people is exacerbated by the visibility of transgender issues. Here, transgender people fall into a dichotomy of invisible versus visible, but both groups are saturated in stigmatization and oppression that contributes towards mental health difficulties.

The present study supports findings from earlier research which depicts high levels of suicidal ideation prior to transition (Transgender Equality Network Ireland, 2012). While participants reflected on "*chemical induced depression*" resulting from hormonal or surgical intervention, all participants demonstrated suicidal ideation during concealment of their gender identity. A reduction in suicidal ideation for five participants after embarking on the decision to transition emerged. For Anna, having to maintain the "*forged persona*" of male for employment whilst trying to transition was associated with her suicide attempt. This suggests continued partial concealment of gender is detrimental to wellbeing and conflicts with research stating an increased risk of suicide if all people are aware of the person's transgender identification (Haas, Rogers & Herman, 2014).

Contact with services remains an elevated time of risk for several reasons, including the poor response in frontline knowledge of transgender issues, service delay, and the power dynamic creating dependency on the medical profession. Transition brings a vulnerable population into contact with professionals who may also hold stigmatizing beliefs towards transgendered people (Dorsen, 2012). Being reliant on a service that demands "*living in role*" prior to hormonal intervention is considered "*cruel*" by participants. Given that "*living in role*" is attached to the male persona it serves to undermine the voices of transgender experiences and requires review.

Emphasis was given to the importance of hormonal intervention in body adaptations enabling gender embodiment but also as a social signifier of gender,

supporting recommendations by the Royal College of Psychiatry (RCP, 2013). Positive feedback from reflected appraisals is desired by participants, and is critical in enhancing self-esteem. Withholding hormones could increase sourcing medication on the black market and perpetuating discrimination and abuse reported by Testa *et al*. (2015).

2.4.1.4 Theme 4: "Transitions to an authentic sense of self: learning how to live again"

When reflecting on the social narratives and discourse that influence understanding of transition, some participants echo the essentialist view of female-ness being related to pregnancy and childbirth. Tauchert (2002) describes how these attempts to reinforce traditional gender roles and gender stereotypes reinforce the hegemonic belief system and institutional demands of conformity. However, when seeking to enquire about post-transition difficulties such as grief or emergence of earlier trauma once dysphoria has reduced, it is important to address the client's framework of identity and how this may be embodied in gender stereotyped roles.

Despite the prevalence of mental health difficulties and loss that participants grappled with, the narratives also described an empowering sense of authenticity and greater self-esteem post-transition, echoing findings from Burdge (2014). Participants' resilience appeared through a variety of coping mechanisms: evolving from concealed intropunitive measures into reliance on interpersonal

relationships and connections with others post-transition. A relationship between increased self-esteem and activism is suggested.

2.4.2 Clinical, societal and service implications

The power differential that historically and contemporarily position people of transgender experience in a pathologising medicalised discourse, stress the need for attuned, allied, clinician relationships within an environment of safety and acceptance. Services need to prioritise the autonomy of the client through provision of comprehensive information of care pathway, knowledge of intersectionality and opportunities to complain without infringement on access to treatment. Clinicians should explicitly promote awareness of human variance and divergence and educate themselves about societal constructs that serve to enforce a gender binary which can lead to distress.

Often marginalised groups rely on a shared terminology that signifies in-group belonging. People that choose to reject this term may be perceived as fracturing group identity and thus be more prone to isolation from group acceptance at a vulnerable period (Broad, 2015). Clinicians should be mindful about the individual needs of their clients and appropriate support groups that meet clients' ideological and personal beliefs should be provided.

2.4.3 Methodological limitations

With a small sample size, the results cannot generalise to all transgender people. The experiences of MTF cannot be conflated to represent FTM transgender, or the

multitude of other gender identities. However, the similarities across narratives and richness of detail provides validity to shared experiences of transition. Furthermore, rejection of terminology created and imposed by Cisgender people onto transgender people is acknowledged within this research. This highlights the restrictive nature of discourse and may have accounted for non-participation for some participants.

2.4.4 Recommendations for future research

The mental health sequelae and disempowerment of transgender people due to conflictual societal gender conventions is emphasised. Future research should aim to investigate the experiences of transgender people who hold additional intersects of reduced privilege, such as racial minorities or those with complex needs, as there is a dearth of information in this field (Coleman *et al.,* 2011).

Moreover, future research should disentangle mental health difficulties related to societal oppression versus gender dysphoria. A paucity of well designed, methodologically rigorous scales to deconstruct these factors compound this issue (Dorsen, 2012). The controversial debate regarding diagnosis of gender dysphoria is ongoing. Salah (2006) describes how diagnosis contributes towards agency and autonomy in lobbying for access to services. In contrast, Butler (2004) avers that diagnosis lends itself to "internalizing some aspect of the diagnosis, conceiving of [themselves] as mentally ill or 'failing' in normality, or both" (p. 82). Deconstructing gender dysphoria from oppression will be useful in contributing to

this debate given the dual elements of access and stigmatization which diagnosis provides.

2.5 Conclusion

This in-depth qualitative study has contributed to the growing literature concerning intersecting systems of oppression for people of transgender experience. Gender dysphoria, whilst entwined within gender norms and conventions, is described as a separate entity that may not require psychological input, or conversely, may be exacerbated by the disempowerment transgender people experience. Further social change in challenging these conventions contribute towards alleviation of the distress transgender people experience.

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Chapter 3: Reflective Paper

Reflections on the importance of Intersectionality and SOCIAL GGRRAAACCEEESSS in psychology

Overall chapter word count (excluding references):3999

3.1 Introduction

Reflection and reflective practice have flourished over recent years in a variety of professional practices. Within some professions it is considered a core competency of the role. This applies to psychology to some degree, dependent on the theoretical model underpinning the bedrock from which the psychologist invokes their practice and research (Finlay, 2008a). While reflection may have more visibility in different professions, the definition and understanding of this can still differ substantially between and within the same professions. Without a consensus on what reflection is, psychologists have to question whether it can still "ring true," assuming there is a single truth to reflection, given the multiple ways in which it is used (Loughran, 2000 in Finlay, 2008, p.1).

In contrast, Ghaye (2000) postulates that striving for reflection within psychological practice is done so with the ambition of being able to manage the uncertainty in our workplace which enables us to work on the edges of order and chaos. Similarly, Mason (1993) suggests it is within our constant search for certainty and a fantasy of being safe within this location that we continue to perpetuate a myth that certainty exists. Thus, we place ourselves in an 'unsafe' position when life and reality show up different to our expectations despite our attempts at controlling factors outside of our control.

Therefore, this paper assumes a position where reflection attempts to review current actions and behaviours that exist within a "state of flow" (Mason, 1993, p.194). These ideas while relevant and current at this moment may later be

refined, whereby new understanding and explanation can be placed alongside existing understanding rather than in replacement of existing knowledge. Here, one works in the context of safe uncertainty; a framework which allows the psychologist to move away from offering definitive solutions, but instead "an evolving state of being" (Mason, 1993, p.197). Evolution is apt given reflection can be thought of as a reflection of one's actions so that continuous learning may be achieved (Schon, 1983).

By introducing the term safe uncertainty, derived from systemic theory and practice, a powerful influence on my stance as an academic-practitioner, this paper will draw upon two main theories. First, Burnham's (2012) SOCIAL GGRRAAACCEEESSS; representing Gender, Geography, Race, Religion, Age, Ability, Appearance, Class, Culture, Ethnicity, Education, Employment, Sexuality, Sexual Orientation, and Spirituality. Conceptualised as visible and invisible, voiced and unvoiced aspects of difference in beliefs, power, and lifestyle. Secondly, Crenshaw's (1989) theory of intersectionality; how the multiplicity of these identities interlock and overlap to create a whole that is greater than its fragmented components, based on privilege and oppression, and, how this intersects within a context of social inequality and systemic injustice. It seems an important theoretical stance, given that critical reflection of my actions in addition to attempts to understand the experiences of others occurs through a lens shaped by these social constructs.

I acknowledge the lack of some of the SOCIAL GGRRAAACCEEESSS in this account. When I foreground particular aspects of my experiences, I inevitably place other elements into the shadows. It is vital that I consider how failing to include these may translate to areas of unexplored diversity within the therapeutic relationship and research. Through the SOCIAL GGRRAAACCEEESSS I highlight, it provides me the opportunity to later reflect on the invisible constructs and intersections that have the potential to sit in my blind spot (Teitelbaum, 1990).

3.2 Themes of transition and identity

It is not a surprise that I have chosen themes of transition or identity, given the parallel process of my transformation over the course of the doctorate and impending graduation to qualified life. It was not until I was part way through analysis, the ability to see the importance of choosing transition as a topic emerged, highlighting an awareness of my blind spots to a factor guiding this research.

Age can often signify particular life transitions or socially acceptable life stages (Burr, 1995). For instance, I naively began the process of the doctorate with an assumption that I would reach a point in which it clicked; a pivotal moment whereby I could say with some confidence I had transitioned to become a clinical psychologist. A coming of age experience that would neatly harness the many years of commitment and dedication. Instead, what has emerged is confidence in the commitment to continuous learning and a belief that the more I learn, the less I

know. Instead of being overwhelmed by this concept, I approach it with a sense of curiosity and interest that activates my seeking system (Panksepp, 1998).

3.3 The intersect of Age, Appearance, and Education

The construct of age in regards to my appearance has however caused some assumptions. There have been several references to appearing younger than my years, and inferences around not having a family particularly in the context of Child and Adolescent Mental Health Services (CAMHS). I approach this as a way of introducing and exploring topics that may otherwise go unspoken. It is also important to recognise the validity to some of these questions: if I have not experienced life transitions or stages, can I adequately provide a base from which these experiences can be understood and explored?

My views on this are currently two-fold: if we all possess our own intersects, we may never know the same experience of the other, and secondly, it emphasises an opportunity for the client to be empowered to be the expert of their experience rather than rely on the psychologist. Approaching these questions in this manner does not stop me from contemplating questions about whether my male colleagues face similar enquiries; through exploration, it appears they do not. I also note the prevalence of men posing these questions and the social significance of this.

However, allowing multiple discourses room to sit alongside one another such as woman/age/partner/employed/psychologist/White-British within a capitalist

society can paint opposing ideas about what I embody and am capable of achieving. For example, within a market economy, competitiveness equates to the survival of the fittest, yet discourses around femininity prevail around facets such as nurturing, emotional, and vulnerable.

In contrast, masculinity can be portrayed through constructs of strong, reliable, and reasoned. Writers suggest it is these misinformed beliefs that encourage women to be overlooked for places of top management or contribute to the 'glass cliff' phenomenon, whereby females are more likely to achieve power in a time of crisis when the likelihood of failure is highest (Bruckmüller & Branscombe, 2009; Burr, 1995). How to approach this requires understanding and leadership tact; knowing when to address these issues and the best forum to do so is essential.

It is important to recognise I am still navigating this political arena and so far I have often found myself relying on an internal moral compass as a guide. For instance, equality is a burgeoning topic within both society and institutions such as the National Health Service (NHS) but potentially serves to deny the concept of equity. By foregrounding equality, it can negate people's experiences of difference and recognition that people do not start from similar positions. It is through the multiplicity of intersected identity frames of each individual we acknowledge these issues to produce a fair system. Part of the role of psychology is to bring focus to this within inter-professional working relationships and create a discourse whereby these matters can be debated.

Rather than continually talking about frustration and lack of social change, the opportunity to harness this into agency and action is crucial. Although a desire to challenge these misinformed and outdated beliefs is present, the place to begin is by challenging my internalisation of these corrosive messages pertaining to gender and opportunities to thrive. It has been through the reciprocal courage, playfulness, and creativity within my relationships with supervisors and appraisal tutor that I have explored such topics, received mentorship, and, have the confidence and curiosity to continue to challenge, seek answers and plough my own furrow.

3.4 The intersect of Gender and Appearance

The definition of transition is "the process or a period of changing from one state or condition to another" (Oxford English Dictionary, 2016). Many of the people of transgender experience I spoke with demonstrated the fluidity and evolving process of transition and left me questioning the value of this terminology. If we culturally expect gender to have a point of finality that clearly distinguishes us from one another, then we begin to contribute through the use of language to a system that oppresses those who do not conform to this ideal and impose a marginalising framework on others around us.

At times throughout the research process, I was reminded by participants of my Cisgender identity through their assumptions of my appearance, curious questioning or statements about my belonging to a different group. In turn, I felt acutely aware of never having prioritised or needing to spotlight this question

against the stark contrast of their accounts of rumination about their gender identity over several years. My bracketing interview highlighted this further and exemplified its importance (Finlay, 2008b). At times, the bracketing interview left me grasping for the right words to convey my experiences, as a 'sense of knowing' my gender identity was not adequate to express this to another (here, my research supervisor). What exactly was intrinsic to me and my experiences that amounted to the label of female?

I answer this as follows, although recognise a superficial grasp and further understanding is needed: I exist within a reciprocal relationship of influence to the societal norms and expectations of a discursive culture. It is in comparison to what we are not that helps to define what we are. Yet, in the process of this research, I have shifted perception on the rigidity of my gender as I feel the blinkers have been removed allowing me to notice the fluidity in all gender expression. I was not blinded to this per se; however, I had rarely foregrounded this. I am sincerely grateful to the participants who via their accounts enabled a deeper intrapersonal exploration of this burgeoning topic.

3.5 The intersect of Sexuality and Sexual Orientation

Often referenced throughout the interviews, assumptions that gender was defined or conveyed through sexuality was evident: to be a person of transgender experience existed within the realm of sexuality: hyper-sexualised or debased, or sexual orientation: historically rooted in fetishism (Bockting, 2009; Mattias de Vries, 2012). The associated consequences of this include a reference point to

other marginalised group within society and incorrect assumptions that sexuality is synonymous with gender.

Sexuality and sexual orientation has been largely absent from discussions on the doctorate training and poses many challenges regarding personal and professional integration (Butler, 2004). One wonders whether implicit messages given in avoiding these topics perpetuates the explicit debate about disclosure and non-disclosure within the profession and therapeutic encounter, and, subverts the power of marginalised groups. In not disclosing my sexual orientation, do I see myself belonging to a majority group identity and thus contribute to the process of marginalised groups having to repeatedly 'come out'? (Franke & Leary, 1991). This tradition of non-disclosure is challenged by many Lesbian, Gay, Bisexual and Transgender (LGBT) therapists (Davies, 1996) and raises important considerations about the power imbalance of disclosure and non-disclosure which I continue to explore.

Smagorinsky (2012) emphasises the detrimental impact the meta experience of difference being synonymous with a defect may have within social systems. Recognition of this, as well as explicitly using difference within the therapeutic encounter will be crucial to enabling the client to frame their understanding of social oppression within this context. In embracing difference, this will hopefully encourage all clients, not just those who identify as non-conforming, empowerment of knowledge relating to influential constructs that shape our ability to navigate the world and relationships within it. In turn, it recognises my

limitations within the relationship and places me in a "not-knowing," curious position (Flaskas, 2002, p.43) so that I may authentically enquire about their lived experience and a co-creation of narratives can occur.

3.6 Acquisition of language within a discursive culture

Cultivating this thesis was difficult; recognising my social constructionist stance meant the process of determining inclusion and exclusion criteria required compromises to meet with ethical approval. For instance, the transgender community is a heterogeneous culture; a myriad of terms exist within it and language is the standard expressive tool we use as a means to communicate ourselves. In a post-structuralist era, this lexicon is quickly evolving, including the community reclaiming terminology that has previously been utilized in oppressive ways, for example, genderqueer (Burdge, 2007).

On reflection, this has further reaching consequences; dichotomies of concepts such as straight, gay, black, white, mental health or conversely mental health difficulties, are often presented within a paradigm of normal and not normal (Burr, 1995). Rigid constructs hold implications for clients, myself and the multidisciplinary team I will become embedded within. A crucial element to moving this newly acquired understanding forwards is the facilitation of challenging these deterministic constructs within a safe and supportive organisational culture.

However, at times I perpetuated the dichotomous approach to gender that is prevalent in our society in my use of terminology. Recognition of this led to the internal challenging of notions that research strives for homogeneous samples as this is not reflective of our society. This attempt to retain a sense of order through categorization emerged as one of the aspects which marginalise and oppress individuals and preserves the social construction of gender as binary. Therefore, restricting my pool of participants to an arbitrary definition of 'male to female transgender' based on conceptualisations proffered in a Western society was in direct contrast to the way in which I see myself as a psychologist and a human being.

Effectively, the very nature of terminology such as 'male to female' places judgements about preconceptions of what constitutes maleness and change within this to the female form. Burr (1995) argues that "our very selves become the product of language" (p.44) and as such introduces a power relation within the dynamic as a researcher recruiting people that may not use these terminologies to identify their selfhood.

Moreover, Wittgenstein (1922) proclaimed "the limits of my language means the limits of my world" (p.5.6) suggesting language is the tool that constructs the narrative of our experiences. A prerequisite for shared language requires a shared culture. Given we are all experiencing our unique version of living, this poses questions about the possibility of a shared 'truthful' narrative when we consider

the intersectionality of our socially constructed experience (Crenshaw, 1989; Parker, 1992).

Burr (1995) avers this is "consciousness raising" (p.122) and leads me to endeavour to become more deliberate in the use of language and raises awareness to its performative action. Importantly, it encourages approaching the client's use of language curiously to make sense of their lived experience and honour the multiplicity of narratives held by people within the discursive culture we reside.

3.7 Power dynamics

The topic above raised further consideration on the use of language to empower or disempower individuals; my research questions assumed a naïve lens through which transgender was a term that participants identified. However, what often emerged throughout interviews was a tenuous relationship with terminology that is created by people of non-transgendered experience and enforced upon a group. This creation of a term served to disempower non-binary people through its imposition and naturally was rejected by some individuals.

Given that the dominant discourse within Western society is slanted towards a patriarchal, white, middle-class lens (Liu, Pickett Jnr & Ivey, 2007), this can serve to devalue anything which falls outside of these privileged categories. Clients that enter into the therapeutic nexus are prone to feel unequal about the power dynamic as the essence of the relationship is unbalanced: clients lay bare their experiences without equal reciprocity, and it is common for clients to consider the therapist as a paragon of psychological health (Dearing & Tangney, 2011). Sartre

(1971/1981) highlights the importance of what is absent within an experience is just as important as what is present. If the client feels their power and agency is lacking within therapeutic interactions, this potentially has the ingredients to undermine any therapeutic alliance and agency for change.

Similarly, when considering power differentials held within knowledge (Foucault, 1976), it must be stated as a middle-class white woman who ascribes to a social science education, I may hold more power than the clients I meet with in regards to economic, political and ideological power (Erdmans, 2004). This, of course, is dependent on the social narrative in which we give power; currently, this exists predominantly within a medical context and is an area of contention for myself as a psychologist. However, this shines a light on an important topic for reflection: in our position as psychologists, is the use of formulation any different in giving voice to our privileged authoritative position and does it consequently act as a way to legitimise our version of events over the clients? (Gergen, 1989).

One way I have contributed to this disempowerment throughout my empirical paper, and other research is failing to offer a truly collaborative analysis of the data, relying on my interpretation while accounting for the hermeneutic circle (Smith, Flowers & Larkin, 2009). Through discussions on my current placement with other psychologists, within a service guided by a recovery model and visible service user movement, I have come to re-evaluate where power is implicitly and explicitly held. By magnifying my researcher position and presumed ability to deconstruct participants' narratives into shared understanding accurately, I neglect

their abilities to collaborate to the process of analysis, and thus the data could be said to lack a richness established through joint analysis. In recognition of this, I envision my future work beginning to incorporate this into applied psychology and research and have started to address this through co-creation of session notes.

3.8 Education, Agency and Activism

I have come to internally spotlight the importance of what I believe is the greatest gift I simultaneously gave myself and was afforded the opportunity to have, as a result of several intersecting SOCIAL GGRRAAACCEEESSS and forms one of these constructs: education. Reflection centres your actions in relation to others as a means of evolving learning, yet without insight into the self, this is only ever partially fulfilled. The notion of constructs precludes the individuality of the self; the self is passive to constructs imposed onto it. It is with the education of both privileges and oppression within the world I traverse, I can begin to challenge assumptions and disempowerment of these constructs and instead turn towards social cultivation. In cultivation, empowerment in my individuality, as well as the intersections of constructs which shape my agency and ability to give voice to my experiences, create space for the possibility of resistance (Nielson, 2013).

A parallel process emerged during the research process and my journey over the past three years. In giving voice, albeit, with the lens of my own intersects to my participants' experiences I have become more of an activist in my personal life, using platforms like social media as a communicative tool to convey this. This collective organisation of a forged community, based on various identity

characteristics (gender, race, class, culture, etc.), is providing an opportunity in the 21st Century for fraternity and solidarity that has been lacking in other generations (Parker, 1992).

However, this also brought to the fore how I must strive to avoid placing myself in a position of power that presumes marginalised groups do not have a voice without a platform of social sciences or myself. Foucault (1976) advocated "where there is power there is also resistance" (p.95) and in the opportunity for resistance, marginalised discourse capitalises into social and personal change. My capacity as an agent for change and simultaneously a conduit of power and oppression within my professional interactions is worthy of consideration; denial of this would deny the existence of privilege and oppression and how I hold the capacity for both within myself.

Recognition of intersecting privilege and oppression casts light on my work with groups that are marginalised within our society. My attempts at being an ally to marginalized groups extend to refugee populations through research interests while on the doctorate. Despite being drawn to advocate for marginalised communities, my ability to contribute to oppressive practices through human fallibility is also present. A contributing factor to embark on this research was a mistake where I misgendered a person of transgender experience. This encounter left me reflecting on my unconscious biases, lack of knowledge and equally shameful and guilty; a reparative action may be considered in part the body of this work. The shame, however, led me to reflect on my assumptions regarding

language and identity, my lack of culturally-sensitive awareness and resulted in growth about identity cultivation.

With the explicit intent of avoiding romanticising the suffering intrinsic to humanity, my experiences working with marginalised populations has reinforced the nature of suffering that indubitably sculpts us yet does not define us. Depicted in historical abuse of race and power highlighted within the following extract from Douglass' oration of 1852

> …Scar tissue on a slave's back- the number of scars, whether a scar was old or relatively fresh- became the subject of a mythology employed to determine a slave's character. Too many scars indicated a rebellious spirit, whereas having few scars meant the slave possessed a docile, obedient spirit (Nielson, 2013, p.39).

It would be idealised to presume that as human beings we are a more rebellious spirit for all the pain and suffering we endure. Yet, I hold as part of my enduring belief in the field of psychology and a person's capacity to move from a position of distress, that growth can result from tragedy, error, fallibility of the human condition and place us on a trajectory that we would never have stumbled across otherwise. This belief does not neglect the recognition of suffering endured but hopes to utilise Vygotsky's (1993) approach to humanity's ability to endure, survive and transcend our differences in a way that we become more than the trauma both/and because of it (Hardy, 1995).

3.9 We take our history into the future

In summary, this reflective paper has contemplated how language is considered a "self–referent system" influenced by the culture in which it is embedded (Burr, 1995, p.90). Layers of privilege and oppression interact to produce a unique human experience that requires a holistic approach if we are to try to understand others. Crucially, I have come to realise that my experiences cannot speak on behalf of others if it does not include or represent others. If the experiential base from which I draw knowledge from remains rooted in a white, middle-class albeit working class background- female, then any generalizations are misguided or at worse inaccurate (Crenshaw, 1989).

Examples of this are rife within psychological practice, for instance, the use of psychometric tests or psychological theories that conceptualise from an androcentric, ethnocentric, and heterocentric lens (Burr, 1998; Mattius de Vries, 2012). We find that although research on women and women's experience is increasing, we must continue to wonder whether the existing knowledge we are proffering as truth is representative of females or whether they instead manipulate females into a framework derived from male experiences. This issue extends further than gender and must be considered to apply to all of the SOCIAL GGRRAAACCEEESSS.

So then, it becomes clearer that the future holds much to learn and make sense of; thus my curiosity and excitement at this prospect is piqued. Although many of the references I have drawn upon are dated for a report, it is only with the knowledge

of our history that we can move forwards. Yalom (2013) tells of the possibility to discover a new meaning through the process of therapy that allows retrospective flooding of old experiences from a new lens of understanding. To contribute to this process as a catalyst while bearing witness to another's life narrative is one of the greatest privileges held in this position.

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Appendix A

Author instructions for the Journal of Transgenderism

General Submission Guidelines

- Each article should be submitted online via the Journal's Manuscript Central site found at https://mc.manuscriptcentral.com/wijt.
- Articles must be formatted double-spaced with ample margins of at least one inch on all sides and the pages should be numbered. The Journal uses the spelling of American English or British English providing usage is consistent throughout. Articles written by those whose primary language is not English should be edited carefully for language prior to submission.
- Due to an anonymous peer review system being employed, please ensure that articles have been properly blinded; author names and affiliations and acknowledgments should not appear anywhere in the main document file. Author names and affiliations are entered in a separate section in the online system for submission of articles.
- Articles should be prepared according to the guidelines in the Publication Manual of the American Psychological Association (6th. Edition, 2009). Guidelines and free tutorials on APA style can be found at http://www.apastyle.org/. This website also contains guidelines on the use of unbiased language and terms related to gender and sexual orientation; see http://www.apastyle.org/manual/supplement/index.aspx.
- At present, the *International Journal of Transgenderism* does not have a fixed word limit for articles, although a typical article will not exceed

6000 words; because of limited space, short articles have a higher chance of acceptance than longer ones of an equivalent standard.

- Authors are responsible for obtaining permission to reproduce copyrighted material from other sources and are required to sign an agreement for the transfer of copyright to the publisher. All accepted manuscripts, artwork, and photographs become the property of the publisher. Number manuscript pages consecutively throughout the paper. Authors should also supply a shortened version of the title suitable for the running head, not exceeding 50 character spaces. Each article should be summarized in an abstract of not more than 300 words and include 3-5 keywords. Please consult our guidance on keywords here. Avoid abbreviations, diagrams, and reference to the text in the abstract.

Review articles

- *International Journal of Transgenderism* will aim to publish 1 or 2 review articles in each issue. Authors intending to submit a review article should check recent issues of the Journal to ensure that no review of the topic they propose to discuss has been published in the journal in recent times. We encourage authors to adhere to the PRISMA guidelines for systematic reviews (see http://www.prisma-statement.org). Review articles may have up to 75 relevant references. Authors contemplating the submission of a literature review article are welcome to contact the Editor-in-Chief to discuss the appropriateness of the topic prior to submission.

Appendix B

Coventry University ethics approval for Chapter One

Certificate of Ethical Approval

Applicant: Suzanne Brown

Project Title: Mental health practitioners' attitudes towards people of transgender experience: A systematic review of the literature

This is to certify that the above named applicant has completed the Coventry University Ethical Approval process and their project has been confirmed and approved as Low Risk

Date of approval: 29 March 2017

Project Reference Number: P52570

Appendix C

Quality Assessment Framework scoring criteria

Caldwell, Henshaw & Taylor (2011).

Question	Yes: 2 points	Partial: 1 point	No: 0 points
Does the title reflect the content? The title should be informative and indicate the focus of the study. It should allow the reader to easily interpret the context of the study. An inaccurate or misleading title can confuse the reader.			
Are the authors Credible? Researchers should hold appropriate academic qualifications and be linked to a professional field relevant to the research			
Does the abstract summarize the key components? The abstract should provide a summary of the study. It should include the aim of the study, outline of the methodology and the main findings. The purpose of the abstract is to allow the reader to decide if the study is of interest to them			
Is there a rationale for undertaking the research clearly outlined? The author should present a clear rationale for the research, setting it in context of any current issues and knowledge of the topic to date			
Is the literature review comprehensive and up to date? The literature review should reflect the current state of knowledge relevant to the study and identify any gaps or conflicts. It should include key or classic studies on the topic as well as up to date literature. There should be a balance of primary and secondary sources			
Is the aim of the research clearly stated? The aim of the study should be clearly stated and should convey what the researcher is setting out to achieve			

Are all ethical issues identified and addressed? Ethical issues pertinent to the study should be discussed. The researcher should identify how the rights of informants have been protected and informed consent obtained. If the research is conducted within the NHS there should be an indication of local research ethics committee approval
Is the methodology identified and justified? The researcher should make clear which research strategy they are adopting i.e. qualitative or quantitative. A clear rationale for the choice should also be provided so that the reader can judge whether the chosen strategy is appropriate for the study at this point the student is asked to look specifically at the questions that apply to the paradigm appropriate to the study they are critiquing.
Quantitative Studies Only: Is the study design clearly identified and is the rational for choice of design evident? The design of the study e.g. survey, experiment should be identified and justified as with the choice of strategy the reader needs to determine whether the design is appropriate for the research undertaken
Is there an experimental hypothesis clearly stated? Are the key variables clearly identified? In experimental research the researcher should provide a hypothesis. This should clearly identify the independent and dependent variable and state their relationship and the intent of the study. In survey research the researcher may choose to provide a hypothesis but it is not essential, and alternatively a research question or aim may be provided
Is the population identified? The population is the total number of units from which the researcher can gather data. It may be individuals, organisations or documentation. Whatever the unit, it must be clearly identified
Is the sample adequately described and reflective of the population? Both the method of sampling and the size of the sample should be stated so that the reader can judge whether the same is representative of the population and sufficiently large to eliminate bias
Is the method of data collection valid and reliable? The process of data collection should be described. The tools or instruments must be appropriate to the aims of the study and the researcher should identify how reliability and validity were assured
Is the method of data analysis valid and reliable? The method of data analysis must be described and justified. Any statistical test used should be appropriate for the data involved.
Qualitative Only: Are the philosophical background and study design identified and the rationale for choice of design evident? The design of the study e.g. phenomenology, ethnography, should be identified and the philosophical background and rationale discussed. The reader needs to consider if it is appropriate to meet the aims of the study.
Are the major concepts identified? The researchers should make clear what the major concepts are but they might not define them. The purpose of the study is to explore the concepts from the perspective of the participants.

Is the context of the study outlined? The researcher should provide a description of the context of the study, how the study sites were determined and how the participants were selected.
Is the selection of participants described and the sampling method identified? Informants are selected for the relevant knowledge or experience. Representativeness is not a criteria and purpose sampling is often used.
Is the method of data collection valid and reliable? / Is the method of data collection auditable? Data collection methods should be described and be appropriate to the aims of the study. The researcher should describe how they assured that the method is auditable
Is the method of data analysis credible and confirmable? The data analysis strategy should be identified, what processes were used to identify patterns and themes. The researcher should identify how credibility and confirmability have been addressed.
<u>All:</u> Are the results presented in a way that is appropriate and clear? Presentation of data should be clear easily interpreted and consistent
Is the discussion Comprehensive? In quantitative studies the results and discussion are presented separately. In qualitative studies these may be integrated. Whatever the mode of presentation the researcher should compare and contrast the findings with that of previous research on the topic. The discussion should be balanced and avoid subjectivity.
<u>Quantitative Only</u>: Are the results generalizable?
<u>Qualitative Only</u>: Are the results transferable?
Is the conclusion comprehensive? Conclusions must be supported by the findings. The researcher should identify any limitations to the study. There may also be recommendations for further research or if appropriate implications for practice in the relevant field.

Appendix D
Quality Assessment Framework for systematic review

Study	Title reflective of content	Authors credible	Abstract summary	Rationale defined	Literature comprehensive	Aim clearly stated	Ethical issues addressed	Methodology identified and iustified	**Quantitative:** Study design identified and rationale given	Hypothesis stated if necessary	Population identified	Sample described and reflective of population	Method of data collection valid/reliable	Data analysis valid and reliable	**Qualitative**: Background and study design	Major concepts identified	Context outlined	Sampling method outlined	Method of data collection valid and reliable	Data analysis credible and confirmable	**All**: Results clear and appropriately presented	Comprehensive discussion	**Quantitative:** Results generalizable	**Qualitative:** Results transferable	Conclusion comprehensive	Total
Agee-Aguayo *et al.* (2016)	1	2	1	2	2	2	1	0	2	2	1	1	1	1	N/A	N/A	N/A	N/A	N/A	N/A	2	1	1	N/A	2	25
Ali *et al*. (2016)	2	1	2	2	2	2	2	1	2	1	2	2	1	1	N/A	N/A	N/A	N/A	N/A	N/A	2	2	0	N/A	2	29
Bowers *et al.* (2015)	2	1	2	2	2	2	1	1	2	2	1	1	1	2	N/A	N/A	N/A	N/A	N/A	N/A	1	2	1	N/A	2	28
Dispenza & O'Hara (2016)	2	1	2	2	2	2	1	1	2	2	2	2	2	2	N/A	N/A	N/A	N/A	N/A	N/A	2	2	1	N/A	2	32

Johnson & Federman (2014)	2	1	2	2	2	1	1	2	2	2	2	2	1	2	N/A	N/A	N/A	N/A	N/A	N/A	2	2	2	N/A	2	31
Kanamori & Cornelius-White (2017)	2	1	1	2	2	2	1	1	2	2	1	1	2	2	N/A	N/A	N/A	N/A	N/A	N/A	2	2	1	N/A	2	29
Kidd *et al.* (2016)	1	1	1	2	1	2	1	1	2	0	2	1	1	2	N/A	N/A	N/A	N/A	N/A	N/A	1	0	0	N/A	1	20
O'Hara *et al.* (2013)	2	1	1	2	1	1	0	2	2	2	1	1	2	2	1	2	1	2	1	2	1	1	1	1	2	35
Riggs & Bartholomaeus (2015)	1	1	1	2	1	1	1	0	1	0	1	1	2	1	N/A	N/A	N/A	N/A	N/A	N/A	1	1	1	N/A	2	19
Riggs & Bartholomaeus (2016a)	1	1	1	1	2	1	1	1	1	1	2	1	1	2	N/A	N/A	N/A	N/A	N/A	N/A	1	1	0	N/A	2	21

Riggs & Bartholomaeus (2016b)	2	1	1	2	2	2	1	1	2	2	2	1	1	2	N/A	N/A	N/A	N/A	N/A	N/A	2	2	1	N/A	1	28
Riggs & Sion (2016)	1	1	1	0	2	0	1	0	1	0	0	1	0	1	N/A	N/A	N/A	N/A	N/A	N/A	2	1	1	N/A	1	14
Willoughby *et al.* (2010)	1	2	1	2	2	2	0	1	1	2	0	1	1	1	N/A	N/A	N/A	N/A	N/A	N/A	1	1	1	N/A	1	21

Appendix E

Kappa inter-rater reliability coefficient scores

Overall inter-rater reliability:

Symmetric Measures

		Value	Asymptotic Standard Error[a]	Approximate T[b]	Approximate Significance
Measure of Agreement	Kappa	.876	.049	9.246	.000
N of Valid Cases		90			

a. Not assuming the null hypothesis.

b. Using the asymptotic standard error assuming the null hypothesis.

Bowers *et al.* (2015) paper:

Symmetric Measures

		Value	Asymptotic Standard Error[a]	Approximate T[b]	Approximate Significance
Measure of Agreement	Kappa	.783	.133	3.679	.000
N of Valid Cases		18			

a. Not assuming the null hypothesis.

b. Using the asymptotic standard error assuming the null hypothesis.

Agee-Aguayo *et al.* (2016) paper:

Symmetric Measures

		Value	Asymptotic Standard Error[a]	Approximate T[b]	Approximate Significance
Measure of Agreement	Kappa	1.000	.000	4.884	.000
N of Valid Cases		18			

a. Not assuming the null hypothesis.

b. Using the asymptotic standard error assuming the null hypothesis.

Kanamori & Cornelius-White (2017) paper:

Symmetric Measures

		Value	Asymptotic Standard Error[a]	Approximate T[b]	Approximate Significance
Measure of Agreement	Kappa	.753	.159	3.298	.001
N of Valid Cases		18			

a. Not assuming the null hypothesis.

b. Using the asymptotic standard error assuming the null hypothesis.

Riggs & Bartholomaeus (2015) paper:

Symmetric Measures

		Value	Asymptotic Standard Error[a]	Approximate T[b]	Approximate Significance
Measure of Agreement	Kappa	.746	.171	4.151	.000
N of Valid Cases		18			

a. Not assuming the null hypothesis.

b. Using the asymptotic standard error assuming the null hypothesis.

Ali *et al.* (2015) paper:

Symmetric Measures

		Value	Asymptotic Standard Error[a]	Approximate T[b]	Approximate Significance
Measure of Agreement	Kappa	1.000	.000	4.243	.000
N of Valid Cases		18			

a. Not assuming the null hypothesis.

b. Using the asymptotic standard error assuming the null hypothesis.

Appendix F

Coventry University ethics approval for Chapter Two

Certificate of Ethical Approval

Applicant: Suzanne Brown

Project Title: Exploring the lived experience of transgender transition

This is to certify that the above named applicant has completed the Coventry University Ethical Approval process and their project has been confirmed and approved as Medium Risk

Date of approval: 15 January 2016

Project Reference Number: P37168

Appendix G

Semi-structured interview questions

Introduction: It is important for you to know that I am interested in you and your experiences. There are no right or wrong answers, and you may find that I will do very little talking as I am here to try to understand your world and life experiences. Please know that if at any time you feel you need to take some time out, we can do that, and we can also stop the interview if you feel you need to.

1. Can you describe what being Transgender means to you?
2. Please tell me how you first identified as female?

a. How long ago was it?

b. What were your thoughts? What did you notice?

c. How did you feel?

3. What sense did you make of this at the time?

a. What helped you cope? –

i. People?

ii. Groups?

iii. Activities?

iv. Information?

4. What led you to decide to transition?

a. What do you think brought this about?

5. What were the stages involved in your transition?

Prompts:

i. How you understood it

ii. How family, friends, colleagues understood it

iii. How society understood it

6. What was your experience whilst transitioning?

Prompts:

i. Psychological impact

ii. Thoughts

iii. Emotions

iv. Stresses

v. Physical impact

vi. Social impact

7. What ways of coping did you use at this time?

Prompts:

i. What made it better?

ii. What made it worse?

8. What was important for you about transitioning?
9. Do you see yourself differently now than you did before transition?
10. Is there anything else that you feel is important for me to know about your transgender transition experience?

Appendix H

Flyer for recruitment

Interested in participating in research?

I am a Trainee Clinical Psychologist at Coventry and Warwick University looking to complete my thesis on the experiences of being transgender; thinking particularly about resilience and identity. This is an exciting and under-researched area within the transgender community.

I am looking to complete 1:1 interviews with volunteers who identify as transgender, these interviews would take around 60-90 minutes. I am looking to recruit 6-8 participants with the interviews taking place at the end of 2015/ beginning 2016. All participant's identity would be anonymised to maintain confidentiality.

It is intended for the results to be published to add to the literature available on transgender experiences, of which there isn't a large amount. The results would also be disseminated back to participants and potentially presented at relevant conferences.

Please would you contact me if you have any questions or would be interested in participating in this exciting project and would like further details.

Suzanne Brown
Tel: 07468419434
Email: browns57@uni.coventry.ac.uk.

Appendix I

Participant information sheet

Study Title: Lived Experiences: Exploring Transgender Transition

Lead Researcher: Suzanne Brown, Trainee Clinical Psychologist

I would like to ask for your assistance with a research study that I am conducting. The study aims to assess the mental health and life experiences of transgender people. Before you decide whether to take part you need to understand why the research is being done and what it would involve for you to take part. Please take time to read the following information carefully.

What is the purpose of the study?

The current research will investigate the experiences and views of transgender people in relation to their experience of identifying and coming out as Trans, specifically during the transition process. Previous research has addressed the mental health impact that transgender people can face, including depression, anxiety, self-harm and suicidal ideation/attempts. Currently, it is not clear what promotes positive adaptations or resilient factors during transition that reduces the suicidal risk post transition.

Why have I been invited to take part?

You identify as transgender (which for the purpose of this study is defined as living as your preferred gender identity, usually different to your assigned

biological birth sex) for 12 months. I am interested in hearing the views and experiences you have had during the process of identifying as transgender. You are over the age of 19 years old and your transition did not occur prior to 1980. You have been invited to take part in the study because you meet these criteria.

How many will be interviewed in the study?

It is hoped that around 6-10 participants who have self-identified as transgender and live within the UK will participate in individual interviews.

Do I have to take part?

It is up to you to decide whether or not you would like to take part and you are free to decline if you would not like to. Please read through this information sheet and if you are interested in taking part in the research or in finding out more about it, we would be grateful if you could let us know by contacting a member of the research team, contact details are at the end of this sheet.

What will I be asked to do?

This is an interview based study. A mutually convenient time and location will be sought where an interview with the principal researcher will be conducted. The interview will be audio recorded and written up, however any quotes from your interview that we may use in any reports will be anonymous so you will not be identifiable as the speaker. Please be aware that any other potentially identifiable information given in the course of the interview (e.g. place of work, job role) will be removed. It is important to mention that there may be a small risk of those who

personally know the participant and their experiences, being able to identify them from what they say about their experiences were they to read excerpts in a published study. Whilst this risk is indeed small, participants should consider this and will be given time to ask questions about this prior to the interview. All other information we gather, including demographic and other personal details will be treated as confidential. You will be asked to consent to being interviewed, audio recorded and the recording being used for the research. You will need to supply some basic demographic details, and talk about your experiences. It is a chance for you to share your thoughts and feelings about your journey. Every care will be taken to minimize distress and you can choose what you wish to share with me. At the end of the interview you will receive contact details of sources of support that are available. The interview will last up to 60 minutes in duration depending on how much you wish to talk. The entire session including completing consent forms and the interview itself will last around 90 minutes.

What are the benefits and disadvantages of taking part?

I cannot promise that the study will help you but the information I obtain could assist to inform the further development of specific access to mental health services for transgender people. It will provide useful information about your views regarding the journey of self-identifying as transgender. The interview also provides a chance for you to add to existing knowledge in this field, focusing on the positive aspects of identifying as transgender. Some people may find this to be a rewarding or upsetting experience, but it is entirely up to you what and how

much information you choose to share with us. You can choose to withdraw from the research without giving a reason at any point during the interview.

What if I agree to take part and then wish to withdraw from the study?

You can withdraw from the study during a period of up to two weeks following the interview, without giving a reason. You can do this through contacting Ms. Suzanne Brown, Trainee Clinical Psychologist or Ms. Jo Kucharska, Supervisor.

Will my participation in the study and data be kept confidential?

Yes. We will follow ethical and legal practice and all information about you will be handled in confidence in accordance with the Data Protection Act 1998. Audio taped and demographic data will be stored securely in locked premises. Codes and false names will be used instead of your own names in order to protect your anonymity. All information which is collected about you during the course of the research will be kept strictly confidential, and information about you will not have your personal details on so that you cannot be recognised. Some parts of this data may be looked at by supervisors and possibly examiners from the University to check that the study is being carried out correctly. All will have a duty of confidentiality to you as a research participant. The information you give as part of the research process will be analysed and used only as part of this study. Confidentiality may only be broken if the researcher is concerned regarding you or someone else coming to harm; this is rarely necessary and I would always endeavour to speak to you about these concerns before breaking confidentiality.

When the study is completed data generated by the study will be stored in a confidential place at Coventry University for five years and then destroyed.

What will happen to the results of the research study?

It is intended for the results of the study to be published on its completion in June 2017. You will not be identified in any report or publication. All participants will be able to receive a summary of the results. Please let Ms. Suzanne Brown, Trainee Clinical Psychologist, know if you would like a copy.

Who is organising/funding the research?

The research is being carried out by Ms. Suzanne Brown, Principal Investigator/ Trainee Clinical Psychologist at Coventry University and Warwick University and Ms. Jo Kucharska, Clinical Director in Clinical Psychology and Behavioural Sciences.

Who has reviewed the study?

This study has been approved by Coventry University Ethics Committee.

What if I have any question or concerns?

For further information or concerns you may have about any aspect of the study, you can contact Ms. Suzanne Brown, Trainee Clinical Psychologist or another member of the research team. If you are still unhappy and wish to complain formally, you can do this through the University complaints procedure, details of which can be obtained below.

What do I do now?

If you are interested in taking part in the research or in finding out more about it, we would be grateful if you could complete the demographic information sheet and return this to Suzanne Brown (browns57@uni.coventry.ac.uk). You will then be contacted by Ms. Suzanne Brown, Trainee Clinical Psychologist, in order to answer any questions or concerns you may have and set up an interview time and date. If you have any further questions about the study, please do not hesitate to contact us. Allowing us to contact you about the study does not mean that you have to take part.

Thank you very much for your time.

Suzanne Brown

Researcher's contact details:
Principal Researcher
Suzanne Brown, Trainee Clinical Psychologist
Coventry University
Priory Street
Coventry CV1 5FB
Email: browns57@uni.coventry.ac.uk

Supervisor details
Ms. Jo Kucharska
Coventry University
Priory Street
Coventry CV1 5FB
Email: aa3539@coventry.ac.uk

Complaints procedure
University Applied Research Committee (UARC)
Chair Prof. Prof Olivier Sparangoe: IRAS-sponsor@coventry.ac.uk

Appendix J

Participant demographic form

Study Title: Lived Experiences: Exploring Transgender Transition

Lead Researcher: Suzanne Brown, Trainee Clinical Psychologist.

Date of Birth:

_____

Gender identity:

I have a clear and constant gender identity as a woman ☐

I have a clear and constant gender identity as a man ☐

I have a clear and constant non-binary gender identity ☐

I have a fluid or variable non binary gender ☐

I have no gender identity ☐

I am uncertain of my gender identity ☐

Other:_____

Sexual orientation:

Bisexual	☐	Gay	☐
Homosexual	☐	Not sure	☐
Heterosexual	☐	Don't define	☐
Pansexual	☐	Polyamorous	☐
BDSM/Kink	☐	Asexual	☐
Lesbian	☐	Other	☐
Genderqueer	☐		

Stage of transition (personal, social medical or surgical process by which you have changed your gender identity):

I have not and do not plan to undergo any part of gender reassignment or transition ☐

Yes I am planning to undergo gender reassignment or transition ☐

I am currently undergoing gender reassignment or transition ☐

I have undergone the process of gender reassignment or transition (this includes non-operative transition) ☐

Other

_____

How do you feel you are perceived by others?

As the gender I identify with ☐

The sex I was assigned at birth ☐

As a Transgender person ☐

Other:

_____

Religion:

_____

Age of transition/coming out:

_____

How long prior to transition did you know that you did not identify with your sex assigned at birth?:

_____

Marital status:

_____

Ethnic origin:

_____

Socio-economic status (per annum):

£0-£25,000 ☐

£25,001-£50,000 ☐

>£50,001 ☐

Location of residence:

_____

Where would be suitable to interview? (times and dates)

_____

Have you used any of the following services for mental health concerns?

GP ☐

Antidepressants ☐

Therapy- NHS ☐

Therapy- Private ☐

Psychiatry ☐

Psychology ☐

Community Mental Health Team_____

In patient services_____

Helpline

_____

Charity

_____

Online Support

_____

Community Support Groups

_____

Other:

_____

Researcher completes this section

Assigned Participant code:

_____

Assigned Pseudonym:

_____

Appendix K

Participant consent form

Study Title: Lived Experiences: Exploring Transgender Transition

Lead Researcher: Suzanne Brown, Trainee Clinical Psychologist

Please read the following points and initial each box to indicate that you agree, sign and date.

I confirm that I have read the Participant Information Sheet for the above and I have understood it. I have had the opportunity to consider all the information given to me, and to ask any questions I have. ☐

I agree to take part in an individual interview. ☐

I consent to the material being published, anonymously. ☐

I give permission for my interview to be audio recorded. ☐

I give permission for the audio recording to be transcribed and used as part of the research, including publication of such material. ☐

I understand that the recording and transcript will be stored securely, and that the recording will be destroyed on completion of the study once transcribed. ☐

I understand that any information I provide will be treated as confidential and anonymous. Confidentiality may only be broken if the researcher is concerned regarding me or someone else coming to harm. ☐

I understand that parts of the data collected during the study may be looked at by the researchers and their supervisors but that the data will not include my real name. I give permission for this. ☐

I understand that my participation is voluntary and that I am free to withdraw from the study at any time, and up to two weeks following my interview ☐

I wish to receive a written summary of the findings of the study. ☐

Please sign and date:

_____ _____ _____

Participant Name (print) Date Signature

Appendix L

Participant debriefing form

Study Title: Lived Experiences: Exploring Transgender Transition
Researchers: Suzanne Brown, Trainee Clinical Psychologist, Ms. Jo Kucharska, Clinical Director in Clinical Psychology Psychology and Behavioural Sciences.

Thank you for taking part in the above study. Your participation is greatly appreciated. You may find the following information useful.

What if I wish to withdraw from the study?
You can withdraw from the study within two weeks of taking part in the interview, without giving a reason. You can do this through contacting Suzanne Brown. In this instance you can have the interview audio recording, the transcription of the interview and your demographic details removed from the study and destroyed.

Aims of Thesis Related Project
To assess the views and experiences of male to female transgender people regarding their experience of transitioning and adaptive skills or resilience during this time. This research takes a humanistic approach, valuing and respecting all diverse gender identities and gender expressions, however it is also an in depth investigation into factors which influence Trans mental health and wellbeing.

Background and existing literature
Evidence from the Trans Mental Health Study 2012 highlights how trans people are experiencing high levels of depression, anxiety, self-harm and suicidal ideation (59% of those surveyed) and suicidal attempts (48% of those surveyed).

Currently, figures from this survey suggest that suicidal ideation is higher pre transition, but falls following transition. I am interested in the factors that influence this so that more positive experiences of identifying as transgender and trans-affirmative evidence can be added to the literature.

Sources of support

If you feel upset following participation in this project, we would encourage you to contact the principal researcher. They will be able to organize the most appropriate form of support for you. To arrange to speak to someone please contact:

Researcher's contact details:

Principal Researcher
Suzanne Brown, Trainee Clinical Psychologist
Coventry University
Priory Street
Coventry CV1 5FB
Email: browns57@university.coventry.ac.uk

You may also find the following numbers of use to you for additional support:

Mental Health Matters 24hour helpline (Tel: 0800 616171) or your GP should you be struggling to cope.
Samaritans Tel: 08457 90 90 90 * (UK)
The Beaumont Society- The largest and longest established transgender support group in the UK. Information Line (24/7/365) 01582 412220.
The Beaumont Society
27 Old Gloucester Street
London
WC1N 3XX

Appendix M

IPA procedure

(Smith, Flowers & Larkin, 2009).

Table 2.4 IPA analysis procedure

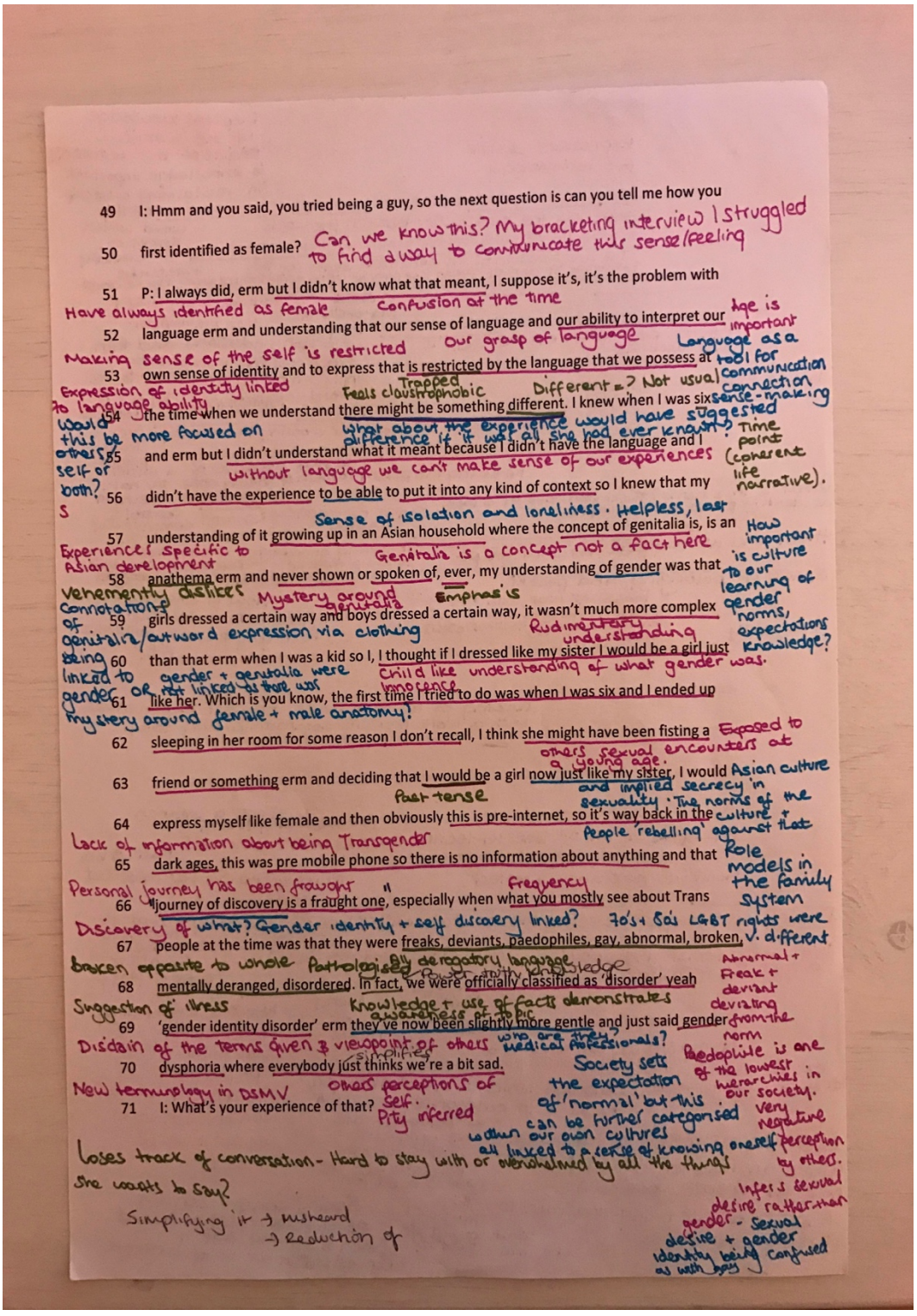
Stage One: Identifying themes in the first case	The transcripts will be read a number of times in order to become familiar with the content. Parts that appear significant or interesting will be annotated and this stage may include preliminary interpretations.
Stage Two: Emerging themes	Once the transcript has been read, I aim to return to the beginning and comment on emerging theme titles. This may involve more psychological terminology and move the response to 'a higher level of abstraction'.
Stage Three: Connecting themes	Connections between emerging themes are sought, here similar themes are clustered, with superordinate themes transpiring. This analysis is an iterative process with emphasis on returning to the text to validate the themes ensuring the participant's account matches what has emerged.
Stage Four: Coherence of data	A table is created in which clusters of themes (subordinate) are labelled under a superordinate theme. At this stage it is suggested to include an identifier of where the data was gathered from, to facilitate finding the original source (name, page, line number). At this stage other themes may be cut from the

	analysis; normally those that are not rich in evidence or do not fit with the emerging themes.
Stage Five: Convergence and divergence in additional data	The next transcripts are now prepared for analysis, repeating steps 1-4 outlined above. Here, the previous superordinate themes gathered form the initial transcript can be used to inform analysis, or it can be set aside and the new data can be categorized without influence of prior findings.
Stage Six: Data prioritization	At this stage, a final table is produced which illuminates all superordinate themes. The focus on which to concentrate on requires prioritization of the data. This prioritization is based on the richness of the account rather than mere prevalence within the data. Previous transcripts are reviewed in light of the chosen superordinate themes, and included within the ongoing analysis.
Stage Seven: A narrative account	The final stage involves translating the previous superordinate and subordinate themes into a narrative. This will include verbatim of the transcript in order to illustrate nuances, explain and justify themes.

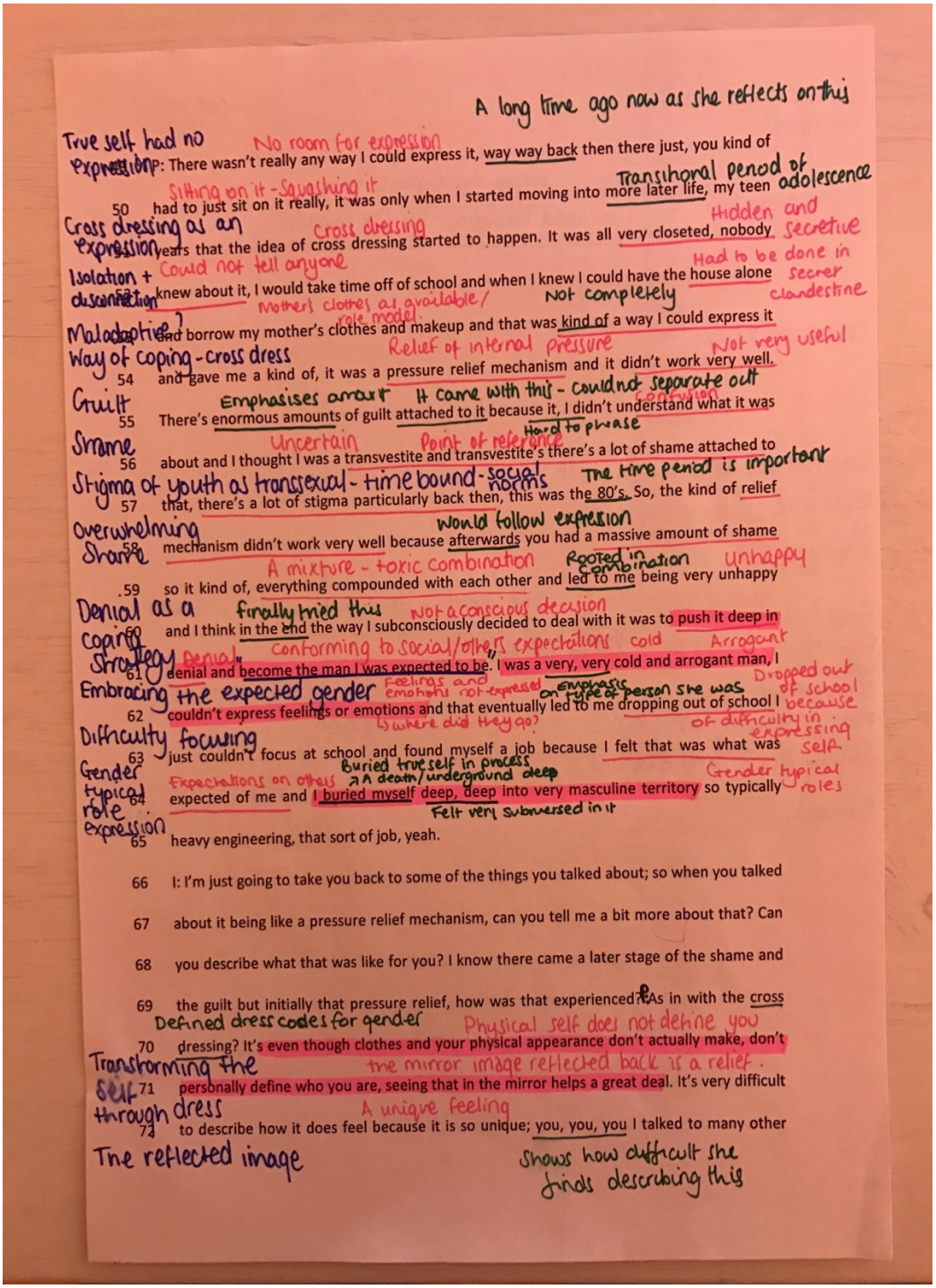
Appendix N

Excerpts from data analysis

Example from participant 2:



Example from participant 4:



Appendix O

Photos of data analysis process

Photo one:

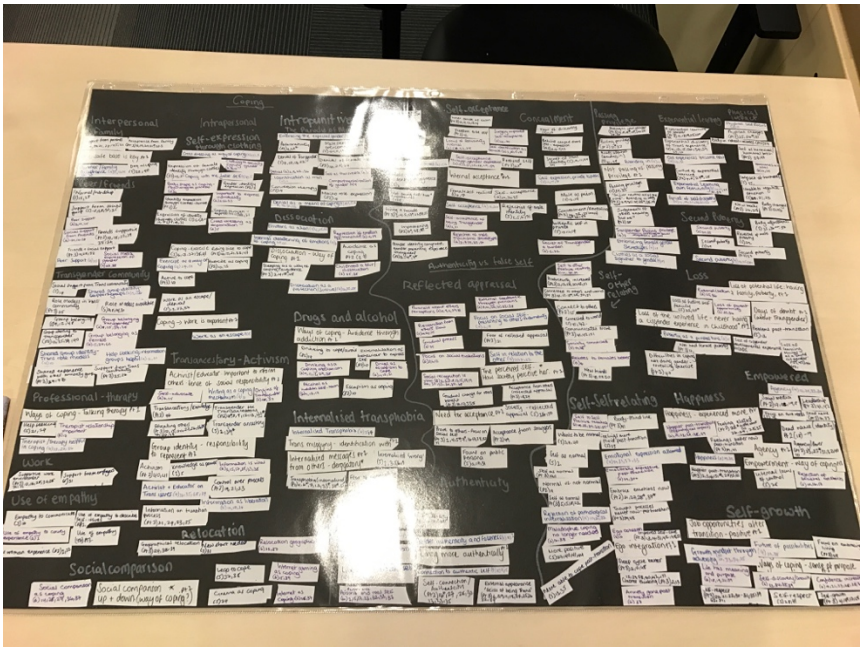
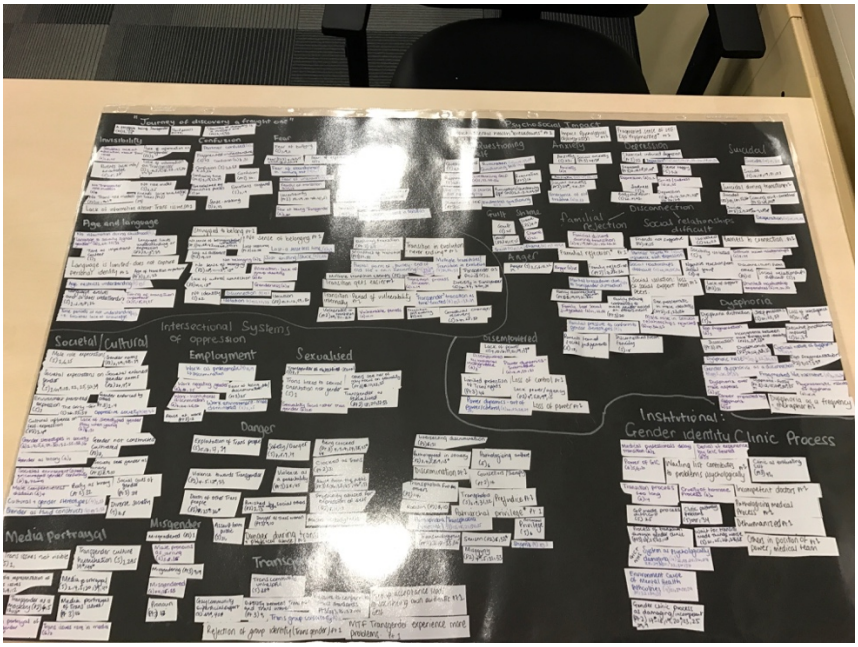


Photo Two:



Appendix P

Example of respondent validation

Email received from participant dated 27th February 2017:

Hello Suzanne, it's good to hear from you. It sounds like things are progressing well.

I would say generally that yes what you have captured seems pretty standard material in that some of the themes I can personally relate to and if not myself my clients would likely to be able to identify with.

In my own work I have been proposing the idea that WE ALL are on the gender identity spectrum and that I would like to get to a place that all definitions of gender identity are unnecessary because in reality gender identity is individual and terms like binary, transgender etc are actually meaningless. But when I've spoken of this with clients around this concept with some of my clients it is warmly received. I certainly get the feeling that some Trans individuals struggle to transition into the image they have for themselves. This put a considerable press on them to "pass" rather than try and "be" who they feel they are.

I hope that this has been of some help to you?

I look forward to hearing from you.

Best wishes,

Name of participant 1